Filing at a Glance

Company:	Aetna Life Insurance Company
Product Name:	2012 DEN- Dental Enhancements (ALIC)
State:	Arkansas
TOI:	H10G Group Health - Dental
Sub-TOI:	H10G.000 Health - Dental
Filing Type:	Form
Date Submitted:	10/31/2012
SERFF Tr Num:	AENX-G128750752
SERFF Status:	Closed-Approved
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	AR062980100004
Implementation Date Requested:	10/31/2012
Author(s):	SPI AetnaSPI
Reviewer(s):	Donna Lambert (primary), Rosalind Minor
Disposition Date:	11/08/2012
Disposition Status:	Approved
Implementation Date:	11/08/2012

State Filing Description:

State: Arkansas **Filing Company:** Aetna Life Insurance Company
TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: 2012 DEN- Dental Enhancements (ALIC)
Project Name/Number: 2012 DEN- Dental Enhancements (ALIC)/AR062980100004

General Information

Project Name: 2012 DEN- Dental Enhancements (ALIC)
Project Number: AR062980100004
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 11/08/2012
State Status Changed: 11/08/2012
Created By: SPI AetnaSPI
Corresponding Filing Tracking Number:

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small and Large
Overall Rate Impact:

Deemer Date:
Submitted By: SPI AetnaSPI

Filing Description:
The purpose of this filing is to support the following options for our dental products:

[PPO and] Fee for Service Dental Products:

Calendar Year Benefit Maximum Flexibility
1) Specify the service categories (preventive, basic or major) to which the calendar year maximum applies.
2) Allow for separate calendar year maximums by service category (preventive, basic or major).
3) Revised the calendar year maximum to consistently show a range of $250 - 10,000 in all plans where inclusion of this maximum is a plan option.

Coverage for counseling on the topics of smoking cessation and nutrition.

[A PPO plan with a maximum allowable amount schedule by service. A member can go to any dentist, in or out-of-network, and the plan will pay no more than the maximum allowable amount. Member may have additional cost sharing, (defined as coinsurance), for amounts above the maximum allowable amount. In-network, the additional cost sharing will be up to the negotiated charge. Out-of-network, the member can be balanced billed up to the provider's full charge.]

Added language that allows an additional cleaning covered at 100% under plans where the member is also covered under an Aetna medical plan and has a specific medical condition or conditions. These medical conditions include pregnancy, coronary artery disease/cardiovascular disease or diabetes.

Revised the orthodontic lifetime maximum to consistently show a benefit range of $250-5,000 in all plans where inclusion of this maximum is a plan option.

Deductibles:
1) Specify the service categories (preventive, basic or major) to which the calendar year deductible applies.
2) Allow for separate calendar year deductibles by service category (preventive, basic or major).

Revised the coinsurance range for Type A (preventive) services to lower the minimum percentage the plan pays in that range from 70% to 50%.

Frequency Limits:
1) Expanded the frequency options for sealants to cover them once per lifetime or once every six months.

2) Reline or rebase of denture once every 6-36 months.
3) Expanded the frequency limits for gingivectomy, osseous surgery and gingival flap procedure.
4) Expanded the frequency options for exams and x-rays to cover them once every 6 months

Under the dental exclusions and limitations section, added variability to support the removal of certain exclusions when those services are covered under the plan.

[DMO Dental Products:

Included an option to cover implants.

Coverage for counseling on the topics of smoking cessation and nutrition.

Added language that allows an additional cleaning covered at 100% under plans where the member is also covered under an Aetna medical plan and has a specific medical condition or conditions. These medical conditions include pregnancy, coronary artery disease/cardiovascular disease or diabetes.

Under the dental exclusions and limitations section, added variability to support the removal of certain exclusions when those services are covered under the plan.

Added a teeth whitening (external bleaching) benefit.

The ability to support a fixed copayment for orthodontic services under a coinsurance plan.]

Company and Contact

Filing Contact Information

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Filing Company Information

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
(860) 273-7546 ext. [Phone]

CoCode: 60054
Group Code: 1
Group Name: Aetna
FEIN Number: 06-6033492

State of Domicile: Connecticut
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$1,150.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

SERFF Tracking #: *AENX-G128750752* ***State Tracking #:*** ***Company Tracking #:*** *AR062980100004*

State: *Arkansas* ***Filing Company:*** *Aetna Life Insurance Company*
TOI/Sub-TOI: *H10G Group Health - Dental/H10G.000 Health - Dental*
Product Name: *2012 DEN- Dental Enhancements (ALIC)*
Project Name/Number: *2012 DEN- Dental Enhancements (ALIC)/AR062980100004*

Company	Amount	Date Processed	Transaction #
Aetna Life Insurance Company	$1,150.00	10/31/2012	64436399

SERFF Tracking #:	*AENX-G128750752*	***State Tracking #:***		***Company Tracking #:***	*AR062980100004*

State:	*Arkansas*	***Filing Company:***	*Aetna Life Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*2012 DEN- Dental Enhancements (ALIC)*		
Project Name/Number:	*2012 DEN- Dental Enhancements (ALIC)/AR062980100004*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	11/08/2012	11/08/2012

SERFF Tracking #:	*AENX-G128750752*	***State Tracking #:***		***Company Tracking #:***	*AR062980100004*

State:	*Arkansas*	***Filing Company:***	*Aetna Life Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
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Project Name/Number:	*2012 DEN- Dental Enhancements (ALIC)/AR062980100004*		

Disposition

Disposition Date: 11/08/2012
Implementation Date: 11/08/2012
Status: Approved

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application	Approved	Yes
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Cover Letter, Attachment A, GR-9N S-09-05 04, GR-9N S-09-20 04, GR-9N S-09-41 01, GR-9N S-20-005 05, GR-9N S-20-020 02, GR-9N S-21-005 05, GR-9N S-21-010 05, GR-9N S-21-020 02, GR-9N S-21-025 01, GR-9N S-22-010 06, GR-9N S-22-020 04, GR-9N S-23-005 , ...	Approved	Yes
Form	Deductible Provisions	Approved	Yes
Form	Coinsurance Provisions	Approved	Yes
Form	Covered Services and Supplies	Approved	Yes
Form	[Limited] [Comprehensive] Dental Expense Insurance	Approved	Yes
Form	Schedule of Dental Care Benefits	Approved	Yes
Form	Comprehensive Dental Expense Insurance (PPO) Plan Features	Approved	Yes
Form	Covered Expenses, Maximum Benefits	Approved	Yes
Form	Dental Coinsurance for SRC Plans	Approved	Yes
Form	Dental Care Schedule	Approved	Yes
Form	Network Primary Care Dentist Services	Approved	Yes

SERFF Tracking #:	*AENX-G128750752*	***State Tracking #:***		***Company Tracking #:***	*AR062980100004*

State:	*Arkansas*	***Filing Company:***	*Aetna Life Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
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Schedule	Schedule Item	Schedule Item Status	Public Access
Form	[Out-of-Network] Primary Care Dentist Services	Approved	Yes
Form	Managed Dental Coinsurance Plan, Comprehensive Dental Expense Insurance	Approved	Yes
Form	Primary Care Services Schedule	Approved	Yes
Form	Dental Care Schedule for Services Provided by [Network] Providers	Approved	Yes
Form	About the [Alternate] PPO Dental [Expense Insurance] [Plan]	Approved	Yes
Form	Dental Expense Coverage	Approved	Yes
Form	Dental Care Schedule	Approved	Yes
Form	[[Comprehensive] [Managed] Dental Expense Insurance Plan]	Approved	Yes
Form	Network Benefits	Approved	Yes
Form	Orthodontic Treatment Rule	Approved	Yes
Form	Replacement Rule	Approved	Yes
Form	Exclusions that Apply to Dental Insurance	Approved	Yes
Form	Glossary Letter C	Approved	Yes

SERFF Tracking #: AENX-G128750752 **State Tracking #:** **Company Tracking #:** AR062980100004

State: Arkansas **Filing Company:** Aetna Life Insurance Company
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Product Name: 2012 DEN- Dental Enhancements (ALIC)
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Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved 11/08/2012	Deductible Provisions	GR-9N S-09-05 04	CERA	Initial		0.000	AL GE GR9N00S0905 V004.PDF
2	Approved 11/08/2012	Coinsurance Provisions	GR-9N S-09-20 04	CERA	Initial		0.000	AL GE GR9N00S0920 V004.PDF
3	Approved 11/08/2012	Covered Services and Supplies	GR-9N S-09-41 01	CERA	Initial		0.000	AL GE GR9N00S0941 V001.PDF
4	Approved 11/08/2012	[Limited] [Comprehensive] Dental Expense Insurance	GR-9N S-20-005 05	CERA	Initial		0.000	AL GE GR9N0S20005 V005.PDF
5	Approved 11/08/2012	Schedule of Dental Care Benefits	GR-9N S-20-020 02	CERA	Initial		0.000	AL GE GR9N0S20020 V002.PDF
6	Approved 11/08/2012	Comprehensive Dental Expense Insurance (PPO) Plan Features	GR-9N S-21-005 05	CERA	Initial		0.000	AL GE GR9N0S21005 V005.PDF
7	Approved 11/08/2012	Covered Expenses, Maximum Benefits	GR-9N S-21-010 05	CERA	Initial		0.000	AL GE GR9N0S21010 V005.PDF

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Product Name: 2012 DEN- Dental Enhancements (ALIC)
Project Name/Number: 2012 DEN- Dental Enhancements (ALIC)/AR062980100004

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
8	Approved 11/08/2012	Dental Coinsurance for SRC Plans	GR-9N S-21-020 02	CERA	Initial		0.000	AL GE GR9N0S21020 V002.PDF
9	Approved 11/08/2012	Dental Care Schedule	GR-9N S-21-025 01	CERA	Initial		0.000	AL GE GR9N0S21025 V001.PDF
10	Approved 11/08/2012	Network Primary Care Dentist Services	GR-9N S-22-010 06	CERA	Initial		0.000	AL GE GR9N0S22010 V006.PDF
11	Approved 11/08/2012	[Out-of-Network] Primary Care Dentist Services	GR-9N S-22-020 04	CERA	Initial		0.000	AL GE GR9N0S22020 V004.PDF
12	Approved 11/08/2012	Managed Dental Coinsurance Plan, Comprehensive Dental Expense Insurance	GR-9N S-23-005 02	CERA	Initial		0.000	AL GE GR9N0S23005 V002.PDF
13	Approved 11/08/2012	Primary Care Services Schedule	GR-9N S-23-010 03	CERA	Initial		0.000	AL GE GR9N0S23010 V003.PDF
14	Approved 11/08/2012	Dental Care Schedule for Services Provided by [Network] Providers	GR-9N S-30-010 07	CERA	Initial		0.000	AL GE GR9N0S30010 V007.PDF
15	Approved 11/08/2012	About the [Alternate] PPO Dental [Expense Insurance] [Plan]	GR-9N 16-025 03	CERA	Initial		0.000	AL GE GR9N0016025 V003.PDF

SERFF Tracking #: AENX-G128750752 **State Tracking #:** **Company Tracking #:** AR062980100004

State: Arkansas **Filing Company:** Aetna Life Insurance Company
TOI/Sub-TOI: H10G Group Health - Dental/H10G.000 Health - Dental
Product Name: 2012 DEN- Dental Enhancements (ALIC)
Project Name/Number: 2012 DEN- Dental Enhancements (ALIC)/AR062980100004

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
16	Approved 11/08/2012	Dental Expense Coverage	GR-9N 18-006 02	CERA	Initial		0.000	AL GE GR9N0018006 V002.PDF
17	Approved 11/08/2012	Dental Care Schedule	GR-9N 18-010 05	CERA	Initial		0.000	AL GE GR9N0018010 V005.PDF
18	Approved 11/08/2012	[[Comprehensive] [Managed] Dental Expense Insurance Plan]	GR-9N 19-006 02	CERA	Initial		0.000	AL GE GR9N0019006 V002.PDF
19	Approved 11/08/2012	Network Benefits	GR-9N 19-010 04	CERA	Initial		0.000	AL GE GR9N0019010 V004.PDF
20	Approved 11/08/2012	Orthodontic Treatment Rule	GR-9N 20-005 03	CERA	Initial		0.000	AL GE GR9N0020005 V003.PDF
21	Approved 11/08/2012	Replacement Rule	GR-9N 20-010 02	CERA	Initial		0.000	AL GE GR9N0020010 V002.PDF
22	Approved 11/08/2012	Exclusions that Apply to Dental Insurance	GR-9N 28-025 04	CERA	Initial		0.000	AL GE GR9N0028025 V004.PDF
23	Approved 11/08/2012	Glossary Letter C	GR-9N 34-015 07	CERA	Initial		0.000	AL GE GR9N0034015 V007.PDF

SERFF Tracking #:	*AENX-G128750752*	***State Tracking #:***	***Company Tracking #:*** *AR062980100004*

State:	*Arkansas*	***Filing Company:***	*Aetna Life Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*2012 DEN- Dental Enhancements (ALIC)*		
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Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

[Schedule of Benefits]

The following provisions apply to your [medical, prescription drug, dental, vision and hearing] expense insurance plan.

This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached [medical, **prescription drug**, dental, vision, and hearing expense sections of this [*Schedule of Benefits*].]

General

This [*Schedule of Benefits*] replaces any [*Schedule of Benefits*] previously in effect under the group insurance policy.

The insurance described in this [*Schedule of Benefits*] will be provided under Aetna Life Insurance Company's policy form GR-29N.

KEEP THIS [SCHEDULE OF BENEFITS] WITH YOUR [BOOKLET-CERTIFICATE].

[Deductible Provisions

[**Covered expenses** applied to the [**out-of-network provider** and **other health care**] **deductibles** will [not] be applied to satisfy the [**network provider** and **other health care**] **deductibles**. **Covered expenses** applied to the [**network provider** and **other health care**] **deductibles** will [not] be applied to satisfy the [**out-of-network provider** and **other health care**] **deductibles**.]

[Covered expenses that are subject to the **deductibles** include **covered expenses** provided under the [medical, **prescription drug,** dental, vision, and hearing] plans.]

[All **covered expenses** accumulate toward the [**network provider, out-of-network provider**, and **other health care**] **deductibles** except for those **covered expenses** identified later in this *Schedule of Benefits*] [and the following:

- **covered expenses** incurred from a **network provider** that are subject to a **maximum allowable amount** to the extent that the **negotiated charge** is more than the **maximum allowable amount.** In that event, the difference between the **negotiated charge** and the **maximum allowable amount** *does not* count toward any **deductibles** under the plan; and
- **covered expenses** incurred from [a provider] [an **out-of-network provider]** [and for **other care health care**] that are subject to **a maximum allowable amount** to the extent that the billed charge is more than the **maximum allowable amount.** In that event, the difference between the billed charge and the **maximum allowable amount** *does not* count toward any **deductibles** under the plan.]

[You [and each of your covered dependents] have separate [calendar year] **deductibles**. [Each of you must meet your **deductible** separately and they cannot be combined.] [This Plan has individual [and family] [calendar year] **deductibles**.]

[Schedule of Benefits]

[Drafting Note:
Option 1: *These calendar year deductible options are available for plans that include standard calendar year deductible limits.]*

[[Calendar Year] Deductible

Individual
This is an amount of **covered expenses** incurred each [calendar year] for which no benefits will be paid. This [calendar year] **deductible** applies separately to you [and each of your covered dependents]. After **covered expenses** reach the [calendar year] **deductible**, this Plan will begin to pay benefits for **covered expenses** for the rest of the [calendar year.]

Family
This is the amount of **covered expenses** that you and your covered dependents incur each [calendar year] for which no benefits will be paid. After **covered expenses** reach this family [calendar year] **deductible**, this Plan will begin to pay benefits for **covered expenses** that you and your covered dependents incur for the rest of the [calendar year].]

[Family Deductible Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual [calendar year] **deductibles,** these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the [calendar year,] the following must happen:

[The combined **covered expenses** that you and each of your covered dependents incur towards the individual [calendar year] **deductibles** must reach this family **deductible** limit in a [calendar year].]

[[One -three] covered persons must individually meet their [calendar year] **deductible** in a calendar year.]

When this occurs in a [calendar year], the individual [calendar year] **deductibles** for you and your covered dependents will be considered to be met for the rest of the [calendar year].

An added benefit of [50%-100%] may be paid if [covered **prescription drug**, medical, dental, vision, and hearing] expenses are incurred by you and your covered dependents, and these expenses are applied against the [calendar year] **deductible**, and they exceed the family **deductible** limit in a [calendar year]. [This added benefit does not count toward any lifetime maximum benefit for you or your covered dependents].]

[Schedule of Benefits]

[Network Provider and Other Health Care [Calendar Year] Deductible

Individual
This is the amount of **covered expenses** that you [and each of your covered dependents] incur each [calendar year] [from a **network provider** and for **other health care**] for which no benefits will be paid. This individual [calendar year] **deductible** applies separately to you [and each of your covered dependents]. After **covered expenses** reach this individual [calendar year] **deductible**, this Plan will begin to pay benefits for **covered expenses** that you incur [from a **network provider** and for **other health care**] for the rest of the [calendar year].]

Family
This is the amount of **covered expenses** that you and your covered dependents incur each [calendar year] [from a **network provider** and for **other health care**] for which no benefits will be paid. After **covered expenses** reach this family [calendar year] **deductible**, this Plan will begin to pay benefits for **covered expenses** that you and your covered dependents incur [from a **network provider** and for **other health care**] for the rest of the [calendar year.]]

[Family Deductible Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual [calendar year] **deductibles,** these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the [calendar year,] the following must happen:

[The combined **covered expenses** that you and each of your covered dependents incur towards the individual [calendar year] **deductibles** must reach this family **deductible** limit in a [calendar year].]

[[One -three] covered persons must individually meet their [calendar year] **deductible** in a calendar year.]

When this occurs in a [calendar year], the individual [calendar year] **deductibles** for you and your covered dependents will be considered to be met for the rest of the [calendar year].

An added benefit of [50%-100%] may be paid if [covered **prescription drug**, medical, dental, vision, and hearing] expenses are incurred by you and your covered dependents from [**network providers** and **other health care]**, and these expenses are applied against the [**network providers** and **other health care]** [calendar year] **deductible**, and they exceed the family **deductible** limit in a [calendar year]. [This added benefit does not count toward any lifetime maximum benefit for you or your covered dependents.]]

[Schedule of Benefits]

[Out-of-Network Provider and Other Health Care [Calendar Year] Deductible

Individual
This is the amount of **covered expenses** that you [and each of your covered dependents] incur each [calendar year] [from an **out-of-network provider** and for **other health care**] for which no benefits will be paid. This individual [calendar year] **deductible** applies separately to you [and each of your covered dependents]. After **covered expenses** reach this individual [calendar year] **deductible**, this Plan will begin to pay benefits for **covered expenses** that you incur [from an **out-of-network provider** and for **other health care**] for the rest of the [calendar year].]

Family
This is the amount of **covered expenses** that you and your covered dependents incur each [calendar year] [from an **out-of-network provider** and for **other health care**] for which no benefits will be paid. After **covered expenses** reach this family [calendar year] **deductible**, this Plan will begin to pay benefits for **covered expenses** that you and your covered dependents incur [from an **out-of-network provider** and for **other health care**] for the rest of the [calendar year].]

[Family Deductible Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual [calendar year] **deductibles,** these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the [calendar year,] the following must happen:

[The combined **covered expenses** that you and each of your covered dependents incur towards the individual [calendar year] **deductibles** must reach this family **deductible** limit in a [calendar year].]

[[One -three] covered persons must individually meet their [calendar year] **deductible** in a calendar year.]

When this occurs in a [calendar year], the individual [calendar year] **deductibles** for you and your covered dependents will be considered to be met for the rest of the [calendar year].

An added benefit of [50%-100%] may be paid if [covered **prescription drug**, medical, dental, vision, and hearing] expenses are incurred by you and your covered dependents [from **out-of-network providers** and for **other health care]**, and these expenses are applied against the [**out-of-network provider** and **other health care]** [calendar year] **deductible**, and they exceed the family **deductible** limit in a [calendar year]. [This added benefit does not count toward any lifetime maximum benefit for you or your covered dependents.]]

[Schedule of Benefits]

[Drafting Note:
Option 2: *These calendar year deductibles are available for plans that include enrollment based calendar year deductible limits. When a person enrolls for family coverage, only the family deductible will apply and not the individual deductible.]*

For purposes of [calendar year] deductible provision below, an individual means an employee enrolled for self only coverage with no dependent coverage and a family means an employee enrolled with one or more dependents. The family **deductible** can be met by one family member, or a combination of family members.

[[Calendar Year] Deductibles

Individual
This is the amount of **covered expenses** that you incur each [calendar year] for which no benefits will be paid. After **covered expenses** reach this individual [calendar year] **deductible**, this Plan will begin to pay benefits for **covered expenses** that you incur for the rest of the [calendar year].

Family
This is the amount of **covered expenses** that you and your covered dependents incur each [calendar year] for which no benefits will be paid. After **covered expenses** reach this family [calendar year] **deductible**, this Plan will begin to pay benefits for **covered expenses** that you and your covered dependents incur for the rest of the [calendar year].]

[Network Provider and Other Health Care [Calendar Year] Deductible

Individual
This is the amount of **covered expenses** that you incur each [calendar year] [from a **network provider** and for **other health care**] for which no benefits will be paid. After **covered expenses** reach this individual [calendar year] **deductible**, this Plan will begin to pay benefits for **covered expenses** that you incur from a [**network provider** and for **other health care**] for the rest of the [calendar year].]

Family
This is the amount of **covered expenses** that you and your covered dependents incur each [calendar year] [from a **network provider** and for **other health care**] for which no benefits will be paid. After **covered expenses** reach this family [calendar year] **deductible**, this Plan will begin to pay benefits for **covered expenses** that you and your covered dependents incur [from a **network provider** and for **other health care**] for the rest of the [calendar year].]

[Schedule of Benefits]

[Out-of-Network Provider and Other Health Care [Calendar Year] Deductible

Individual
This is the amount of **covered expenses** that you incur each [calendar year] [from an **out-of-network provider** and for **other health care**] for which no benefits will be paid. This individual [calendar year] **deductible** applies separately to you. After **covered expenses** reach this individual [calendar year] **deductible**, this Plan will begin to pay benefits for **covered expenses** that you incur [from an **out-of-network provider** and for **other health care**] for the rest of the [calendar year].]

Family
This is the amount of **covered expenses** that you and your covered dependents incur each [calendar year] [from an **out-of-network provider** and for **other health care**] for which no benefits will be paid. After **covered expenses** reach this family [calendar year] **deductible**, this Plan will begin to pay benefits for **covered expenses** that you and your covered dependents incur [from an **out-of-network provider** and for **other health care**] for the rest of the [calendar year].]

[Common Accident Deductible Limit
This limit applies when two or more family members are injured in the same **accident**. The common **accident deductible** limit places a limit on your **deductible** expenses when **covered expenses** are applied toward the separate [calendar year] **deductibles** for [**network providers**, **out-of-network providers** and for **other health care**]. When this occurs, and all **covered expenses** related to the **accident** in that [calendar year] and the following [calendar year] exceed the common **accident deductible** limit, this Plan will then pay the excess amount based on this Plan **coinsurance** percentage. The added benefit will be reduced by any family **deductible** limit benefit amount paid for the same **covered expenses**.] [This added benefit does not count toward any lifetime maximum benefit for you and your covered dependents.]

[Deductible Carryover
Under this feature, any **covered expenses** that you incur in the last [two-three months] of a [calendar year] that apply toward that year's [calendar year] **deductibles** for **[network providers, out-of-network providers** and **other health care]** will also count toward the following year's **[network providers, out-of-network providers** and **other health care] deductibles.**]

[Separate Accident Benefit
An additional benefit is payable for all **covered expenses** incurred on an outpatient basis due to an **injury**. The **injury** must be caused by an **accident** and the treatment must be received no later than the day after the **injury**.]

[Schedule of Benefits]

Coinsurance Provisions

Coinsurance
This is the percentage of your **covered expenses** that this Plan pays and the percentage of **covered expenses** that you pay.

[As to **covered expenses** incurred from a **network provider**, coinsurance also includes any amount by which the **negotiated charge** exceeds a **maximum allowable amount** under the plan.] [As to **covered expenses** incurred from a [provider] [**out-of-network provider** and for **other health care]**, coinsurance also includes any amount by which the billed charge exceeds a **maximum allowable amount** under the plan.]

The percentage that this Plan pays is referred to as the "Plan" "**coinsurance**" or the "plan payment percentage". Once applicable **deductibles** have been met, this Plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The **coinsurance** percentage may vary by the type of expense. Refer to your [*Schedule of Benefits*] for **coinsurance** amounts for each covered benefit.

[Drafting Note:
Option 1: *These coinsurance limit options are available for plans that include standard coinsurance limits.]*

[**[Coinsurance] Limits**
The [**Coinsurance]** Limit is the maximum amount you are responsible to pay [for **coinsurance**] for **covered expenses** during the [calendar year]. This Plan has an individual [and family] [**coinsurance]** limit. [As to the individual [**coinsurance]** limit, each of you must meet your [**coinsurance]** limit separately and they cannot be combined and applied towards one limit.]

[Certain **covered expenses** do not apply toward these Plan **[coinsurance]** limits. See list below.]

Individual
Once the amount of eligible expenses you [or your covered dependents] have paid during the [calendar year] meets the individual [**coinsurance]** limit, this Plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the [calendar year] for that person.]

[Family
Once the amount of eligible expenses you or your covered dependents have paid during the [calendar year] meets this family [**coinsurance**] limit, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the [calendar year] for all covered family members.]

[Family Coinsurance Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual [calendar year] **coinsurance limits,** these expenses will also count toward a family **coinsurance limit**.]

[Schedule of Benefits]

[To satisfy this family **coinsurance limit** for the rest of the [calendar year,] the following must happen:

[The family **coinsurance limit** is a cumulative **coinsurance limit** for all family members. The family **coinsurance limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **coinsurance limit** amount in a [calendar year].]

[[One-three] [family members have individually satisfied their individual **coinsurance limits** in a [calendar year]. Once these family members have each satisfied their individual **coinsurance limit**, the individual **coinsurance limits** are considered met for the remaining family members for the rest of the [calendar year].]

[The [**coinsurance]** limit applies to [**network provider, out-of-network provider,** and **other health care**] benefits.]

[You have separate [**coinsurance]** limits for [**network provider, out-of-network provider,** and **other health care**] benefits. You are not able to combine [**network provider, out-of-network provider,** and **other health care**] **covered expenses** and apply them toward one limit.]]

[Network Provider and Other Health Care Coinsurance Limits

Individual
Once the amount of eligible [**network provider** and **other health care]** expenses you [or your covered dependents] have paid during the [calendar year] meets the individual [**coinsurance**] limit, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the [calendar year] for that person.]

[Family
Once the amount of eligible [**network provider** and **other health care]** expenses you or your covered dependents have paid during the [calendar year] meets this family [**coinsurance**] limit, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the [calendar year] for all covered family members.]

[Family Coinsurance Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual [calendar year] [**network provider** and **other health care] coinsurance limits,** these expenses will also count toward a family [**network provider** and **other health care] coinsurance limit**.

To satisfy this family [**network provider** and **other health care] coinsurance limit** for the rest of the [calendar year,] the following must happen:

[The family **coinsurance limit** is a cumulative **coinsurance limit** for all family members. The family [**network provider** and **other health care] coinsurance limit** can be met by a combination of family members with no single individual within the family contributing more than the individual [**network provider** and **other health care] coinsurance limit** amount in a [calendar year].]

[Schedule of Benefits]

[[One-three] [family members have individually satisfied their individual [**network provider** and **other health care] coinsurance limits** in a [calendar year]. Once these family members have each satisfied their individual [**network provider** and **other health care] coinsurance limit**, the individual [**network provider** and **other health care] coinsurance limits** are considered met for the remaining family members for the rest of the [calendar year].]

[Out-of Network Provider and Other Health Care Coinsurance Limits

Individual
Once the amount of eligible [**out-of-network provider** and **other health care]** expenses you [or your covered dependents] have paid during the [calendar year] meets the individual [**coinsurance**] limit, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the [calendar year] for that person.]

[Family
Once the amount of eligible [**out-of-network provider** and **other health care]** expenses you [or your covered dependents] have paid during the [calendar year] meets this family [**coinsurance**] limit, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the [calendar year] for all covered family members.]

[Family Coinsurance Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual [calendar year] [**out-of-network provider** and **other health care] coinsurance limits,** these expenses will also count toward a family [**out-of-network provider** and **other health care] coinsurance limit**.

To satisfy this family [**out-of-network provider** and **other health care] coinsurance limit** for the rest of the [calendar year,] the following must happen:

[The family **coinsurance limit** is a cumulative **coinsurance limit** for all family members. The family [**out-of-network provider** and **other health care] coinsurance limit** can be met by a combination of family members with no single individual within the family contributing more than the individual [**out-of-network provider** and **other health care] coinsurance limit** amount in a [calendar year].]

[[One-three] [family members have individually satisfied their individual [**out-of-network provider** and **other health care] coinsurance limits** in a [calendar year]. Once these family members have each satisfied their individual [**out-of-network provider** and **other health care] coinsurance limit**, the individual [**out-of-network provider** and **other health care] coinsurance limits** are considered met for the remaining family members for the rest of the [calendar year].]

[Schedule of Benefits]

[Drafting Note:
Option 2: *These coinsurance limits are available for plans that include enrollment based coinsurance limits. When a person enrolls for family coverage, only the family coinsurance limit will apply and not the individual coinsurance limit.]*

[For purposes of the following coinsurance provisions, an individual means an employee enrolled for self only coverage with no dependents coverage and a family means an employee enrolled with one or more dependents.]

[[Coinsurance] Limits

The [**Coinsurance]** Limit is the maximum amount you are responsible to pay [for **coinsurance**] for **covered expenses** during the [calendar year]. This Plan has an individual [and family] [**coinsurance]** limit.

[Certain **covered expenses** do not apply toward these **[coinsurance]** limits. See list below.]

Individual
Once the amount of eligible expenses you have paid during the [calendar year] meet the Individual [**coinsurance**] limit this Plan will pay 100% of **covered expenses** that apply toward the limit for you for the remainder of the [calendar year].

Family
The Family [**coinsurance**] limit can be met by a combination of family members or by any single individual within the family. Once the amount of eligible expenses paid during the [calendar year] meets this family [**coinsurance**] limit, this Plan will pay 100% of the family's **covered expenses** that apply toward the limit for the rest of the [calendar year].

[The [**coinsurance]** limit applies to [**network provider**, **out-of-network provider** and **other health care**] benefits.]

[You have separate [**coinsurance]** limits for [**network provider, out-of-network provider,** and **other health care**] benefits. You are not able to combine [**network provider, out-of-network provider,** and **other health care**] **covered expenses** and apply them toward one limit.]]

[Network Provider and Other Health Care Coinsurance Limits

Individual
Once the amount of eligible [**network provider** and **other health care]** expenses you have paid during the [calendar year] meets the individual [**coinsurance**] limit, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the [calendar year] for that person.

Family
The Family [**coinsurance**] limit can be met by a combination of family members or by any single individual within the family. Once the amount of eligible [**network provider** and **other health care]** expenses paid during the [calendar year] meets this family [**coinsurance**] limit, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the [calendar year] for all covered family members.]

[Schedule of Benefits]

[Out-of Network Provider and Other Health Care Coinsurance Limits

Individual
Once the amount of eligible [**out-of-network provider** and **other health care]** expenses you have paid during the [calendar year] meets the individual [**coinsurance**] limit, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the [calendar year] for that person.

Family
The Family [**coinsurance**] limit can be met by a combination of family members or by any single individual within the family. Once the amount of eligible [**out-of-network provider** and **other health care]** expenses paid during the [calendar year] meets this family [**coinsurance**] limit, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the [calendar year] for all covered family members.]

[Expenses That Do Not Apply to Your Coinsurance Limits
Certain **covered expenses** do not apply toward this Plan's **coinsurance** limits. These include:

[• Expenses applied toward a **deductible**;
- Charges over the **recognized** [**charge]**;
- **Covered expenses** incurred from a **network provider** that are subject to a **maximum allowable amount** to the extent that the **negotiated charge** is more than the **maximum allowable amount.** In that event, the difference between the **negotiated charge** and the **maximum allowable amount** *does not* count toward any **coinsurance limit** under the plan;
- **Covered expenses** incurred from [a provider] [an **out-of-network provider]** [and for **other care health care**] that are subject to **a maximum allowable amount** to the extent that the billed charge is more than the **maximum allowable amount.** In that event, the difference between the billed charge and the **maximum allowable amount** *does not* count toward any **coinsurance limit** under the plan;
- Expenses applied toward a **copayment**;
- Any **covered expenses** which are payable by **Aetna** at 50%;
- Expenses incurred for outpatient treatments, including [any outpatient **prescription drugs**], [**mental disorder**] treatment expenses, and [**substance abuse**] treatment expenses;
- Non-**covered expenses**;
- Expenses incurred for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an **urgent care provider**;
- Certain other **covered expenses** (see list in the *Schedule of Benefits*); and
- Expenses that are not paid, or [**precertification**] penalties because the required [**precertification**] for the service(s) or supply was not obtained from **Aetna**.]

Aetna Life Insurance Company
[Schedule of Benefits]

Important Information

Covered Services and Supplies that are Subject to a Maximum Allowable Amount

For **covered expenses** incurred from **network providers** and **out-of-network providers,** this Plan will pay **covered expenses** up to maximum allowable amounts. These maximum allowable amounts are shown in this *Schedule of Benefits*.

Network

N**etwork providers** have contracted with **Aetna**, an affiliate or third party vendor to provide health care services and supplies to **Aetna** plan members at a reduced fee called the **negotiated charge**. You will not have to pay any balance bills above the **negotiated charge** for those covered services and supplies.

However, if the **negotiated charge** for a **network provider** is more than the maximum allowable amount for a service and supply as shown in the *Schedule of Benefits*, then you will be responsible for any difference between the **negotiated charge** and the maximum allowable amounts. *This means that you will have to pay to the **network provider** any amount above the maximum allowable amount for that service and supply in addition to any other cost-sharing required of you by this Plan such as **coinsurance**, **deductibles** and **copays***. If the **negotiated charge** is more than the maximum allowable amount**,** *you are responsible for the difference* and that difference does not count toward any **deductible** or **coinsurance limit** under this Plan.

Out-of-Network

If the charge of an **out-of-network provider** is more than the maximum allowable amount for a service and supply, as shown in the *Schedule of Benefits*, then you will also be responsible for any difference between the billed charge and the maximum allowable amounts. *This means that you will have to pay to the provider any amount above the maximum allowable amount for that service and supply in addition to any other cost-sharing required of you by this Plan such as **coinsurance** and **deductibles***. If the billed charge is more than the maximum allowable amount**,** *you are responsible for the difference* and that difference does not count toward any **deductible** or **coinsurance limit** under this Plan.

[Policyholder: ABC Company
Group Policy Number: 123456
Effective Date: January 1, 2004]

Aetna life Insurance Company
[Limited][Comprehensive] Dental Expense Insurance
[Schedule of Benefits]

PLAN FEATURES	
[Calendar Year Deductible	$25-200 Individual $50-600 Family]
[**Type A Expenses**	$25-200 Individual $50-600 Family]
[**Type B Expenses**	$25-200 Individual $50-600 Family]
[Type C Expenses	$25-200 Individual $50-600 Family]
[The calendar year **deductible** applies to all **covered expenses** [except Type A, B and C Expenses].]	
[Lifetime Individual Deductible	$25-200]
[**Type A Expenses**	$25-200]
[**Type B Expenses**	$25-200]
[Type C Expenses	$25-200]
[The lifetime individual **deductible** applies to all **covered expenses** [except Type A, B and C Expenses].]	

[Calendar Year Deductible Carryover Applies]

[Calendar Year Family Deductible Limit Applies]

[**Covered expenses** that are subject to the **deductible** include Medical **Prescription Drug**, Dental, Vision, and Hearing expenses provided under the **Aetna** Medical, **Prescription Drug**, Dental, Vision, Hearing plan.]

[**Orthodontic Deductible** $25-1,000

The orthodontic **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the orthodontic **deductible**, the plan will begin to pay benefits for covered orthodontic expenses for the rest of the calendar year.]

Aetna life Insurance Company
[Limited][Comprehensive] Dental Expense Insurance
Schedule of Benefits

[Plan Coinsurance

Please refer to the listing of **covered expenses** and the percentage payable appearing below. The percentage the plan will pay varies by the type of expense.

PLAN COINSURANCE	
Type A Expenses	50%-100%
Type B Expenses	[30%-100%] [Not Covered]
Type C Expenses	[30%-100%] [Not Covered]
Orthodontic Treatment	[30%-100%] [Not Covered]]

[Plan Coinsurance Limit [Includes] [Excludes] [plan **deductible**].

Individual Plan Coinsurance Limit: [$0 - $10,000]

Family Plan Coinsurance Limit: [$0 - $30,000]]

[Certain **covered expenses** do not apply toward the plan **coinsurance** limit and the family plan **coinsurance** limit. These include:

- Expenses applied toward a **deductible** or **copay** amount.
- Expenses above the **recognized charge**.
- **Covered Expenses** incurred for the following:
  List all **covered expense** categories]

Aetna life Insurance Company
[Limited][Comprehensive] Dental Expense Insurance
Schedule of Benefits

[Calendar Year Maximum Benefit	$250-10,000]
[Type A Expenses	$250-10,000]
[Type B Expenses	$250-10,000]
[Type C Expenses	$250-10,000]
[The calendar year maximum benefit applies to all **covered expenses** [except Type A, B and C Expenses].]	
[Orthodontic Treatment	$250-10,000]

[The most the plan will pay for **covered expenses** incurred by any one covered person in a calendar year is called the calendar year maximum benefit.

Covered expenses that are subject to the Calendar Year Maximum Benefit include medical, **Prescription Drug**, Dental, Vision, and Hearing expenses provided under the **Aetna** Medical, **Prescription Drug**, Dental, Vision, Hearing plan.]

[Orthodontic Lifetime Maximum Benefit

Orthodontic Lifetime Maximum Benefit $250-10,000

The most the plan will pay for **covered expenses** incurred by any one covered person is called the orthodontic lifetime maximum benefit.]

Aetna life Insurance Company
[Limited][Comprehensive] Dental Expense Insurance
Schedule of Benefits

[Lifetime Maximum Benefit

Lifetime Maximum Benefit $1,000-50,000

The most the plan will pay for **covered expenses** incurred by any one covered person during their lifetime is called the **Lifetime Maximum** Benefit.

Covered expenses that are subject to the **Lifetime Maximum** Benefit include medical **Prescription Drug**, Dental, Vision, and Hearing expenses provided under the **Aetna** Medical, **Prescription Drug**, Dental, Vision, Hearing plan.]

[Lifetime Maximum Benefit Automatic Yearly Restoration
At the beginning of each new benefit period, the amount up to $100-$5,000 which:

(1) Has been counted against your **Lifetime Maximum** Benefit; and
(2) Has not been previously restored

will automatically be restored without action on your part. Evidence of good health will not be required. However, your insurance must be in force and restoration is not available during the "extended insurance period".]

[Policyholder: ABC Company
Group Policy Number: 123456
Effective Date: January 1, 2004]

Aetna Life Insurance Company
[Schedule of Benefits]

The plan covers certain dental expenses. The following are the only covered **dentist** charges for services and supplies.

If:

- A charge is made for an unlisted service given for the dental care of a specific condition; and
- The list includes one or more services that, under standard practices, are separately suitable for the dental care of that condition, then the charge will be considered to have been made for a service that would have produced a professionally acceptable result, as determined by Aetna.

[Dental Care Coverage]

[Schedule of Dental Care Benefits]

[TYPE A SERVICES

VISITS AND X-RAYS

Office visit during regular office hours, for oral examination (limited to [2-6 visits every year] [one visit every 6 months])

Prophylaxis (cleaning) (limited to [2-6 treatments per year] [one treatment every 6 months])

Adult

Child (limited to covered persons under age 14-30)

Topical application of fluoride, (limited to [1-4 course of treatment per year] [one application every 6 months] [and to covered persons under age 14-30])

Sealants, per tooth (limited to [1-2 application every 1-5 years] [one per lifetime] [one application every 6 months] for permanent [bicuspids and] molars only, [and to covered persons under age 14-30])

Bitewing X-rays (limited to 1-4 sets [per year] [every 6 months])

Entire denture series consisting of at least 14 films, including bitewings if necessary, or panoramic film (limited to 1-8 sets every [1-5 years] [every 6 months])

Vertical bitewing X-rays (limited to 1-4 set every [1-5 years] [every 6 months])

SPACE MAINTAINERS Includes all adjustments within six months after installation (limited to 1-2 course of treatment per year and to covered persons under age 14-30)

Fixed (unilateral or bilateral)

Removable (unilateral or bilateral)

Recement Space Maintainers]

Aetna Life Insurance Company
[Schedule of Benefits]

[TYPE B SERVICES

VISITS AND EXAMS
Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
Emergency palliative treatment, per visit

X-RAYS AND PATHOLOGY
Periapical X-ray (single films up to 13-25 films)
Intraoral, occlusal view, maxillary or mandibular
Histopathologic examination of oral tissue

RESTORATIVE Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges.
Amalgam restoration
Primary and permanent
1 surface
2 surfaces
3 surfaces
4 or more surfaces
Resin restoration (anterior)
1 surface
2 surfaces
3 surfaces
4 or more surfaces
Resin restoration (posterior)
1 surface
2 surfaces
3 surfaces
4 or more surfaces
Retention pins (per tooth)
Stainless steel crowns, prefabricated, primary tooth (limited to 1-4 procedures per year)
Stainless steel crowns, prefabricated, permanent tooth (limited to 1-4 procedures per year)
Resin crown, prefabricated (excluding temporary crowns) (limited to 1-4 procedures per year)
Recementing inlays or crowns
Recementing bridges
Sedative filling

ORAL SURGERY - Includes local anesthetics and routine post-operative care
Extractions
Erupted tooth for exposed root
Coronal remnants
Surgical removal of erupted tooth/root tip
Root removal - exposed root or erupted tooth
Impacted Teeth
Removal of impacted tooth (soft tissue)
Odontogenic Cysts and Neoplasms
Incision and drainage of abcess]

[TYPE B SERVICES (continued)

Aetna Life Insurance Company
[Schedule of Benefits]

Removal of odontogenic cyst or tumor
Other Surgical Procedures
Surgical removal of root tip, root recovery
Surgical exposure of impacted or unerupted tooth to aid eruption
Alveoplasty in conjunction with extractions - per quadrant
Alveoplasty not in conjunction with extractions - per quadrant
Removal of exostosis – per site
Frenectomy
Excision of hypreplastic tissue – per arch

NUTRITIONAL COUNSELING and TOBACCO COUNSELING (limited to nutritional counseling for the control of dental disease and tobacco counseling for the control and prevention of oral disease)]

Aetna Life Insurance Company
[Schedule of Benefits]

[TYPE C SERVICES

RESTORATIVE Cast or processed restorations and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge. (Limited to 1-4 procedures per year)

- Inlays and Onlays, metallic
  - Inlay, 1 surface
  - Inlay, 2 surfaces
  - Inlay, 3 or more surfaces
  - Onlay, 2 surfaces
  - Onlay, 3 surfaces
  - Onlay, 4 or more surfaces
- Inlays and Onlays, porcelain/ceramic
  - Inlay, 1 surface
  - Inlay, 2 surfaces
  - Inlay, 3 or more surfaces
  - Onlay, 2 surfaces
  - Onlay, 3 surfaces
  - Onlay, 4 or more surfaces
- Inlays and Onlays, resin-based composite
  - Inlay, 1 surface
  - Inlay, 2 surfaces
  - Inlay, 3 or more surfaces
  - Onlay, 2 surfaces
  - Onlay, 3 surfaces
  - Onlay, 4 or more surfaces
- Crowns
  - Resin
  - Resin with base metal
  - Resin with noble metal
  - Porcelain
  - Porcelain with base metal
  - Porcelain with noble metal
  - Metallic (full cast)
  - Metallic (3/4 cast)
  - Cast post and core
  - Prefabricated post and core
- Pontics
  - Cast with base metal
  - Cast with noble metal
  - Porcelain with base metal
  - Porcelain with noble metal
  - Resin with base metal
  - Resin with noble metal]

Aetna Life Insurance Company
[Schedule of Benefits]

[TYPE C SERVICES (continued)

Dentures and Partials - (Fees for dentures and partial dentures include relines, rebases and adjustments within 6-36 months after installation. Fees for relines and rebased include adjustments within 6-36 months after installation. Specialized techniques and characterizations are not eligible.)

Complete denture, upper or lower (limited to 1-4 procedures per year)
Partial denture, upper or lower (limited to 1-2 procedure per year)
Resin base (including any conventional clasps, rests and teeth)
Cast metal base (including any conventional clasps, rests and teeth)
Adjust complete denture, upper or lower (limited to 1-4 procedures per year)
Adjust partial denture, upper or lower (limited to 1-4 procedures per year)
Repair broken acrylic, complete denture, upper or lower (limited to 1-2 procedure per year)
Replace one tooth on complete denture (limited to 1-2 procedure per year)
Repair acrylic, cast frame, broken clasp (limited to 1-2 procedure per year)
Replace broken tooth, partial (limited to 1-2 procedure per year)
Add tooth to existing partial denture (limited to 1-2 procedure per year)
Add clasp to existing partial (limited to 1-2 procedure per year)
Rebase, complete denture, upper or lower (limited to 1-4 procedures per year)
Rebase, partial denture, upper or lower (limited to 1-4 procedures per year)
Reline, complete denture, upper or lower (chairside) (limited to 1-2 procedure per 1-3 years)
Reline, partial denture, upper or lower (chairside) (limited to 1-2 procedure per 1-3 years)
Reline, complete denture, upper or lower (laboratory) (limited to 1-2 procedure per 1-3 years)
Reline, partial denture, upper or lower (laboratory) (limited to 1-2 procedure per 1-3 years)
Interim partial denture, upper or lower (stayplate), anterior only (limited to 1-4 procedures per year)
Special tissue conditioning, per denture (limited to 1-2 procedure per year)

ORAL SURGERY - Includes local anesthetics where necessary and post-operative care
Surgical removal of impacted tooth
Partially bony
Completely bony

ENDODONTICS
Pulp capping
Pulpotomy
Apexification/recalcification (limited to one procedure per year)
initial visit
interim medication replacement
final visit
Apicoectomy/periradicular surgery (limited to one procedure per year)
Anterior
Bicuspid, first root
Molar, first root
Each additional root
Retrograde filling, per root
Root amputation, per root]

Aetna Life Insurance Company
[Schedule of Benefits]

[TYPE C SERVICES (continued)

Root canal therapy, including necessary X-rays (limited to one procedure per year)
- Anterior
- Bicuspid
- Molar root canal therapy

PERIODONTICS

Occlusal adjustment (other than with an appliance or restoration)
- Limited
- Complete

Gingivectomy or gingivoplasty - per quadrant (limited to 1-3 teeth per quadrant, every 1-5 years)

Gingivectomy or gingivoplasty - per tooth (limited to 1-2 per site, every 1-5 years)

Gingival flap procedure, including root planing - per quadrant (limited to 1-2 per quadrant every 1-5 years)

Scaling and root planing - per quadrant (limited to once every 6-12 months)

Periodontal maintenance procedures following surgical therapy (limited to once every 6-12 months)

Localized delivery of chemotherapeutic agents

Occlusal guard for bruxism only (limited to 1-4 every 1-5 years)

Osseous surgery (including flap entry and closure) - per quadrant (limited to 1-4 per quadrant, every 4-5 years)

Pedicle soft tissue graft

Free soft tissue graft

Subepithelial connective soft tissue graft

Soft tissue allograft

Combined connective tissue and double pedicle graft]

[ANESTHESIA – Only when provided in conjunction with a covered surgical procedure

General anesthesia - first 30 minutes

General anesthesia - each additional 15 minutes

Intravenous sedation first 30 minutes

Intravenous sedation each additional 15 minutes]

[ORTHODONTICS

Orthodontic screening exam (when no Orthodontic Procedure is performed)

Comprehensive orthodontic treatment
- Adolescent
- Adult

Post Treatment Stabilization

Removable inhibiting appliance to correct thumb sucking

Fixed or cemented inhibiting appliance to correct thumb sucking]

[Policyholder: ABC Company
Group Policy Number: 123456
Effective Date: January 1, 2004]

Aetna Life Insurance Company
Comprehensive Dental Expense Insurance (PPO)
[Schedule of Benefits]

PLAN FEATURES		
PLAN FEATURES	**[NETWORK]**	**[OUT-OF-NETWORK]**
[Calendar Year Deductible] [Individual $25-200 Family $50-600]		
[**Type A Expenses**	Individual $25-200 Family $50-600	Individual $25-200 Family $50-600]
[**Type B Expenses**	Individual $25-200 Family $50-600	Individual $25-200 Family $50-600]
[**Type C Expenses**	Individual $25-200 Family $50-600	Individual $25-200 Family $50-600]
[The calendar year **deductible** applies to all **covered expenses** [except Type A, B and C Expenses].]		
[Lifetime Individual Deductible] [$25-200]		
[**Type A Expenses**	$25-200	$25-200]
[**Type B Expenses**	$25-200	$25-200]
[**Type C Expenses**	$25-200	$25-200]
[The lifetime individual **deductible** applies to all **covered expenses** [except Type A, B and C Expenses].]		

Aetna Life Insurance Company
[Schedule of Benefits]

[Network Calendar Year Deductible Carryover Applies]

[Network and Out-of-Network Calendar Year Family Deductible Limit Applies]

[**Covered expenses** that are subject to the **deductible** include Medical **Prescription Drug**, Dental, Vision, and Hearing expenses provided under the **Aetna** Medical, **Prescription Drug**, Dental, Vision, Hearing plan.]

[Orthodontic Deductible
The orthodontic **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the orthodontic **deductible**, the plan will begin to pay benefits for covered orthodontic expenses for the rest of the calendar year.]

	[NETWORK]	**[OUT-OF-NETWORK]**
[Orthodontic **Deductible** $25-1,000]	[$25-1,000]	[$25-1,000]

[Policyholder: ABC Company
Group Policy Number: 123456
Effective Date: January 1, 2004

Aetna Life Insurance Company
Comprehensive Dental Expense Insurance (PPO)
[Schedule of Benefits]

[Plan Coinsurance

[Please refer to the listing of **covered expenses** and the percentage payable appearing below. The percentage the plan will pay varies by the type of expense.]

PLAN FEATURES		
	[**NETWORK**]	[**OUT-OF-NETWORK**]
[**Plan Coinsurance** 50% - 100%; [up to the Maximum Allowable Amount shown on the Dental Care Schedule]]		
[**Type A Expenses**	50% - 100%; [up to the Maximum Allowable Amount shown on the Dental Care Schedule]	50% - 100%; [up to the Maximum Allowable Amount shown on the Dental Care Schedule] Not Covered]
[Type B Expenses	30% - 100% [up to the Maximum Allowable Amount shown on the Dental Care Schedule]	30% - 100%; [up to the Maximum Allowable Amount shown on the Dental Care Schedule] Not Covered]
[Type C Expenses	30% - 100% [up to the Maximum Allowable Amount shown on the Dental Care Schedule]	30% - 100% [up to the Maximum Allowable shown on the Dental Care Schedule]; Not Covered]
[Orthodontic Treatment	30% - 100% [up to the Maximum Allowable Amount shown on the Dental Care Schedule]	30%- 100% [up to the Maximum Allowable Amount shown on the Dental Care Schedule] ; Not covered]

[Plan Coinsurance Limit [Includes] [Excludes] [plan **deductible**] and [includes] [excludes] [maximum allowable amounts]]

[Individual Plan Coinsurance Limit:

- [For network expenses: $0-$10,000.]
- [For out-of-network expenses: $0-$10,000.]
- [For network and out-of-network expenses combined: $0-$10,000.]]

[Family Plan Coinsurance Limit.

- [For network expenses: $0-$30,000.]
- [For out-of-network expenses: $0-$30,000.]
- [For network and out-of-network expenses combined: $0-$30,000.]]

Aetna Life Insurance Company
[Schedule of Benefits]

[Certain **covered expenses** do not apply toward the plan **coinsurance** limit and the family plan **coinsurance** limit. These include:

- Expenses applied toward a **deductible** or **copay** amount.
- Expenses above the **recognized charge**.
- **Covered Expenses** incurred for the following:
  List all **covered expense** categories]

[Calendar Year Maximum Benefit

	[**NETWORK**]	[**OUT-OF-NETWORK**]
[Calendar Year Maximum Benefit $250-10,000]		
Type A Expenses	$250-10,000	$250-10,000
Type B Expenses	$250-10,000	$250-10,000
Type C Expenses	$250-10,000	$250-10,000
The calendar year maximum benefit applies to all **covered expenses** except Type [A, B and C] Expenses.		
Orthodontic Treatment	$250-10,000	$250-10,000]

The most the plan will pay for **covered expenses** incurred by any one covered person in a calendar year is called the Calendar Year Maximum Benefit.

The calendar year maximum benefit applies to network and out-of-network covered dental expenses combined.

The calendar year maximum benefit does not apply to network **covered expenses**. However, a calendar year maximum benefit applies to out-of-network **covered expenses**.

Covered expenses that are subject to the Calendar Year Maximum Benefit include medical, **Prescription Drug**, Dental, Vision, and Hearing expenses provided under the **Aetna** Medical, **Prescription Drug**, Dental, Vision, Hearing plan.]

Aetna Life Insurance Company
[Schedule of Benefits]

[Orthodontic Lifetime Maximum Benefit

[**Orthodontic Lifetime Maximum**: $250-10,000]

[All network and out-of-network covered orthodontia expenses apply to the orthodontic **lifetime maximum**.]

[Dental Emergency Maximum Benefit

	NETWORK	**OUT-OF-NETWORK**
Dental Emergency Maximum: [$10 - 1,000]	[$10 – 1,000]	[$10 – 1,000]
The most the plan will pay for **covered expenses** incurred a covered person for any one Dental Emergency is called the Dental Emergency Maximum.]		

[Lifetime Maximum Benefit

	NETWORK	**OUT-OF-NETWORK**
Lifetime Maximum Benefit: [$1,000 - 50,000]	[$1,000 - 50,000]	[$1,000 - 50,000]

The most the plan will pay for **covered expenses** incurred by any one covered person during their lifetime is called the **Lifetime Maximum** Benefit.]

[The **Lifetime Maximum** Benefit applies to covered network and out-of-network expenses combined.]

[The **Lifetime Maximum** Benefit does not apply to covered network expenses. However, a **Lifetime Maximum** Benefit applies to covered out-of-network expenses.]

[Covered expenses that are subject to the **Lifetime Maximum** Benefit include medical **Prescription Drug**, Dental, Vision, and Hearing expenses provided under the **Aetna** Medical, **Prescription Drug**, Dental, Vision, Hearing plan.]]

[Lifetime Maximum Benefit Automatic Yearly Restoration
At the beginning of each new benefit period, the amount up to $100 - $5,000:

(1) Has been counted against your **Lifetime Maximum** Benefit; and
(2) Has not been previously restored;

will automatically be restored without action on your part. Evidence of good health will not be required. However, your insurance must be in force and restoration is not available during the "extended insurance period."]

[Policyholder: ABC Company
Group Policy Number: 123456
Effective Date: January 1, 200

Aetna Life Insurance Company
Dental Care Coverage
Schedule of Dental Care Benefits

The plan covers certain dental expenses. The following are the only covered **dentist** charges for services and supplies.

[TYPE A SERVICES

VISITS AND X-RAYS

Office visit during regular office hours, for oral examination (limited to [2-6 visits every year] [1-6 visits every 6 months])

Prophylaxis (cleaning) (limited to [1-2 treatments every 6-12 months] [one treatment every 6 months])

Adult

Child (limited to covered persons under age 14-30)

Topical application of fluoride, (limited to [1-4 courses of treatment per year] [one application every 6 months] [and to covered persons under age 14-30])

Sealants, per tooth (limited to [1-2 applications every 1-5 years] [one per lifetime] [one application every 6 months] for permanent [bicuspids and] molars only [and to covered persons under age 14-30])

Bitewing X-rays (limited to 1-4 sets [per year] [every 6 months])

SPACE MAINTAINERS Includes all adjustments within six months after installation (limited to 1-2 courses of treatment per year and to covered persons under age 14-30)

Fixed (unilateral or bilateral)

Removable (unilateral or bilateral)]

[TYPE B SERVICES

VISITS AND EXAMS

Emergency palliative treatment, per visit

X-RAYS AND PATHOLOGY

Periapical X-ray (single films up to 13-25 films)

Intraoral, occlusal view, maxillary or mandibular]

Aetna Life Insurance Company
Schedule of Benefits

[TYPE B SERVICES (continued)

RESTORATIVE Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in one surface will be considered as a single restoration.)

- Amalgam restoration
  - Primary and permanent
    - 1 surface
    - 2 surfaces
    - 3 surfaces
    - 4 or more surfaces
- Resin restoration (anterior)
  - 1 surface
  - 2 surfaces
  - 3 surfaces
  - 4 or more surfaces
- Resin restoration (posterior)
  - 1 surface
  - 2 surfaces
  - 3 surfaces
  - 4 or more surfaces
- Retention pins (per tooth)
- Recementing inlays or crowns
- Recementing bridges
- Sedative filling

ORAL SURGERY - Includes local anesthetics and routine post-operative care

- Extractions
  - Erupted tooth for exposed root
  - Coronal remnants
  - Surgical removal of erupted tooth/root tip
  - Root removal - exposed root or erupted tooth
- Impacted Teeth
  - Removal of impacted tooth (soft tissue)
- Odontogenic Cysts and Neoplasms
  - Incision and drainage of abcess
- Other Surgical Procedures
  - Surgical removal of root tip, root recovery
  - Surgical exposure of impacted or unerupted tooth to aid eruption
  - Alveoplasty in conjunction with extractions - per quadrant
  - Alveoplasty not in conjunction with extractions - per quadrant

NUTRITIONAL COUNSELING and TOBACCO COUNSELING (limited to nutritional counseling for the control of dental disease and tobacco counseling for the control and prevention of oral disease)]

Aetna Life Insurance Company
Schedule of Benefits

[TYPE C SERVICES

RESTORATIVE Cast or processed restorations and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge. (Limited to 1-4 procedures per year)

- Crowns
  - Resin
  - Resin with base metal
  - Resin with noble metal
  - Porcelain
  - Porcelain with base metal
  - Porcelain with noble metal
  - Metallic (full cast)
  - Metallic (3/4 cast)
- Cast post and core
- Prefabricated post and core
- Pontics
  - Cast with base metal
  - Cast with noble metal
  - Porcelain with base metal
  - Porcelain with noble metal
  - Resin with base metal
  - Resin with noble metal
- Stainless steel crowns, prefabricated, primary tooth
- Stainless steel crowns, prefabricated, permanent tooth
- Resin crown, prefabricated (excluding temporary crowns)

Dentures and Partials - (Fees for dentures and partial dentures include relines, rebases and adjustments within 6-36 months after installation. Fees for relines and rebased include adjustments within 6-36 months after installation. Specialized techniques and characterizations are not eligible.)

- Complete denture, upper or lower (limited to 1-4 procedures per year)
- Partial denture, upper or lower (limited to 1-2 procedure per year)
  - Resin base (including any conventional clasps, rests and teeth)
  - Cast metal base (including any conventional clasps, rests and teeth)
- Adjust complete denture, upper or lower (limited to 1-4 procedures per year)
- Adjust partial denture, upper or lower (limited to 1-4 procedures per year)
- Rebase, complete denture, upper or lower (limited to 1-4 procedures per year)
- Rebase, partial denture, upper or lower (limited to 1-4 procedures per year)
- Special tissue conditioning, per denture (limited to 1-2 procedure per year)]

Aetna Life Insurance Company
Schedule of Benefits

[TYPE C SERVICES (continued)

ORAL SURGERY - Includes local anesthetics where necessary and post-operative care
- Surgical removal of impacted tooth
  - Partially bony
  - Completely bony

ENDODONTICS
- Pulp capping
- Pulpotomy
- Apicoectomy/periradicular surgery (limited to one procedure per year)
  - Anterior
  - Bicuspid, first root
  - Molar, first root
  - Each additional root
- Retrograde filling, per root
- Root amputation, per root
- Root canal therapy, including necessary X-rays (limited to one procedure per year)
  - Anterior
  - Bicuspid
  - Molar root canal therapy

PERIODONTICS
- Gingivectomy or gingivoplasty - per quadrant, limited to 1-2 per quadrant, every 1-5 years
- Gingivectomy or gingivoplasty - per tooth, limited to 1-2 per site, every 1-5 years
- Gingival flap procedure, including root planing - per quadrant
- Scaling and root planing (limited - per quadrant, limited to once every 6-12 months)
- Periodontal maintenance procedures following surgical therapy (limited to once every 6-12 months)
- Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, limited to [1-2 procedure every 3-5 years] [1-4 per lifetime]
- Osseous surgery (including flap entry and closure) - per quadrant, limited to 1-2 per quadrant, every 1-5 years]

[Policyholder: ABC Company
Group Policy Number: 123456
Effective Date: January 1, 2004

Aetna Life Insurance Company
[Dental Care Coverage]
[Schedule of Dental Care Benefits]

THIS SCHEDULE APPLIES TO SERVICES PROVIDED BY [NETWORK and OUT-OF-NETWORK] PROVIDERS

[Type A Expenses: Diagnostic and Preventive Care]

	[**NETWORK**] [50-100%]	[**OUT-OF-NETWORK**] [50-100%]
	Maximum Allowable Amount	
[**VISITS AND X-RAYS**		
Office visit during regular office hours, for oral examination (limited to [2-6 visits every year] [one visit every 6 months])	[$2-156]	[$2-156]
Prophylaxis (cleaning) (limited to [2-6 treatments per year] [one treatment every 6 months])		
Adult	[$4-148]	[$4-148]
Child	[$3-107]	[$3-107]
Topical application of fluoride, (limited to [1-4 courses of treatment per year] [one treatment every 6 months] [and to covered persons under age 14-30])	[$3-58]	[$3-58]
Sealants, per tooth (limited to [1-2 application every 1-5 years][one application per lifetime] [one application every 6 months] for permanent bicuspids and molars only, [and to covered persons under age 14-30])	[$9-87]	[$9-87]
Bitewing x-rays (limited to 1-4 set [per year] [every 6 months])	[$2-82]	[$2-82]
Entire dental series; including bitewings; or panoramic film (limited to 1-8 sets every [1-5 years] [6 months])	[$8-176]	[$8-176]
Vertical bitewing X-rays (limited to 1-4 sets every [1-5 years] [6 months])]	[$6-96]	[$6-96]

Aetna Life Insurance Company
[Schedule of Dental Care Benefits]

[Type B Expenses: Basic Restorative Care]

	[NETWORK]	[OUT-OF-NETWORK]
[VISITS AND X-RAYS		
Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)	[$11-272]	[$11-272]
Emergency palliative treatment, per visit]	[$2-153]	[$2-153]
[X-RAY AND PATHOLOGY		
Periapical x-rays (single films up to 13-25 films)	[$1-29]	[$1-29]
Intra-oral, occlusal view, maxillary or mandibular	[$2-36]	[$2-36]
Upper or lower jaw, extra-oral	[$4-54]	[$4-54]
Biopsy and histopathologic examination of oral tissue]	[$4-427]	[$4-427]
[ORAL SURGERY		
Extractions		
Exposed root or erupted tooth	[$4-290]	[$4-290]
Surgical removal of erupted tooth	[$7-409]	[$7-409]
Impacted Teeth		
Removal of tooth (soft tissue)	[$8-445]	[$8-445]
Odontogenic Cysts and Neoplasms		
Incision and drainage of abscess	[$5-2,392]	[$5-2392] Deleted: ,
Removal of odontogenic cyst or tumor	[$5-638]	[$5-638]
Other Surgical Procedures		
Alveoplasty, in conjunction with extractions - per quadrant	[$2-312]	[$2-312]
Alveoplasty, not in conjunction with extraction - per quadrant	[$6-557]	[$6-557]
Sialolithotomy: removal of salivary calculus	[$16-1,339]	[$16-1,339]
Closure of salivary fistula	[$13-3,168]	[$13-3,168]
Excision of hyperplastic tissue	[$16-423]	[$16-423]
Removal of exostosis	[$17-1,580]	[$17-1,580]
Transplantation of tooth or tooth bud	[$33-1,063]	[$33-1,063]
Closure of oral fistula of maxillary sinus	[$20-1,024]	[$20-1,024]
Sequestrectomy	[$10-1,441]	[$10-1,441]
Crown exposure to aid eruption	[$7-664]	[$7-664]
Removal of foreign body from soft tissue	[$5-228]	[$5-228]
Frenectomy	[$12-575]	[$12-575]
Suture of soft tissue injury]	[$5-3,134]	[$5-3,134]

Aetna Life Insurance Company
[Schedule of Dental Care Benefits]

	[NETWORK]	**[OUT-OF-NETWORK]**
	Maximum Allowable Amount	
[**PERIODONTICS**		
Occlusal adjustment (other than with an appliance or by restoration)	[$5-408]	[$5-408]
Root planing and scaling, per quadrant (limited to 1-4 separate quadrants every 1-2 years)	[$8-241]	[$8-241]
Root planing and scaling – 1 to 3 teeth per quadrant (limited to 1-4 per site every 1-2 years)	[$5-173]	[$5-173]
Gingivectomy, per quadrant (limited to 1-2 per quadrant every 1-5 years)	[$25-613]	[$25-613]
Gingivectomy, 1 to 3 teeth per quadrant, (limited to 1-2 per site every 1-5 years)	[$4-332]	[$4-332]
Gingival flap procedure - per quadrant (limited to 1-2 per quadrant every 1-5 years)	[$5-962]	[$5-962]
Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1-2 per site every 1-5 years)	[$5-659]	[$5-659]
Periodontal maintenance procedures following active therapy (limited to 1-2 per year)	[$4-184]	[$4-184]
Localized delivery of chemotherapeutic agents]	[$3-85]	[$3-85]
[ENDODONTICS		
Pulp cap	[$3-91]	[$3-91]
Pulpotomy	[$6-286]	[$6-286]
Apexification/recalcification	[$6-725]	[$6-725]
Apicoectomy	[$17-939]	[$17-939]
Root canal therapy, including necessary x-rays		
Anterior	[$7-903]	[$7-903]
Bicuspid]	[$30-1,134]	[$30-1,134]
[RESTORATIVE DENTISTRY Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in 1 surface will be considered as a single restoration.)		
Amalgam restorations	[$4-363]	[$4-363]
Resin-based composite restorations [(other than for molars)]	[$4-386]	[$4-386]
Pins		
Pin retention, per tooth, in addition to amalgam or resin restoration	[$1-99]	[$1-99]
Crowns (when tooth cannot be restored with a filling material)		
Prefabricated stainless steel	[$8-448]	[$8-448]
Prefabricated resin crown (excluding temporary crowns)	[$8-321]	[$8-321]
Recementation		
Inlay	[$2-156]	[$2-156]
Crown	[$2-156]	[$2-156]
Bridge]	[$1-133]	[$1-133]
[**NUTRITIONAL COUNSELING and TOBACCO COUNSELING (**limited to nutritional counseling for the control of dental disease and tobacco counseling for the control and prevention of oral disease)**]**	[$6-87]	[$6-87]

Aetna Life Insurance Company
[Schedule of Dental Care Benefits]

[Type C Expenses: Major Restorative Care]

	[**NETWORK**]	[**OUT-OF-NETWORK**]
	Maximum Allowable Amount	
[ORAL SURGERY		
Impacted Teeth		
Removal of tooth (partially bony)	[$12-558]	[$12-558]
Removal of tooth (completely bony)	[$20-626]	[$20-626]
Brush biopsy]	[$2-142]	[$2-142]
[PERIODONTICS		
Osseous surgery, (including flap and closure), 1 to 3 teeth per quadrant (limited to 1-4 per quadrant every 1-5 years)	[$18-975]	[$18-975]
Osseous surgery, (including flap and closure), per quadrant (limited to 1-4 per site every 1-5 years	[$30-1,202]	[$30-1,202]
Soft tissue graft procedures	[$7-1,268]	[$7-1,268]
Clinical Crown Lengthening - Hard Tissue	[$8-836]	[$8-836]
Full mouth debridement (limited to 1-4 per lifetime)	[$26-190]	[$26-190]
Bone grafts – first site in quadrant (limited to 1-4 per lifetime)	[$15-492]	[$15-492]
Bone grafts – each additional site in quadrant (limited to 1-4 per lifetime)]	[$2-346]	[$2-346]
[ENDODONTICS		
Root canal therapy, including necessary x-rays		
Molar]	[$37-1,394]	[$37-1,394]
[RESTORATIVE. Inlays, onlays, labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge (limited to 1-2 per tooth every 1-10 years) (See *Replacement Rule*).		
Inlays/Onlays-Metallic or Porcelain/Ceramic		
Inlay, 1 or more surfaces	[$16-1,605]	[$16-1,605]
Onlay, 2 or more surfaces	[$29-1,614]	[$29-1,614]
Inlays/Onlays-Resin-based composite		
Inlay, 1 or more surfaces	[$16-1518]	[$16-1518]
Onlay, 2 or more surfaces	[$29-1614]	[$29-1614]
Labial Veneers		
Laminate-chairside	[$21-708]	[$21-708]
Resin laminate – laboratory	[$11-1,136]	[$11-1,136]
Porcelain laminate – laboratory	[$20-1,593]	[$20-1,593]
Crowns		
Resin	[$21-470]	[$21-470]
Resin with noble metal	[$37-1,585]	[$37-1,585]
Resin with base metal	[$37-1,551]	[$37-1,551]

Aetna Life Insurance Company
[Schedule of Dental Care Benefits]

	[**NETWORK**]	[**OUT-OF-NETWORK**]
	Maximum Allowable Amount	
Porcelain	[$37-1,723]	[$37-1,723]
Porcelain with noble metal	[$46-1,498]	[$46-1,498]
Porcelain with base metal	[$46-1,098]	[$46-1,098]
Base metal (full cast)	[$32-1,378]	[$32-1,378]
Noble metal (full cast)	[$32-1,378]	[$32-1,378]
Metallic (3/4 cast)	[$32-1,507]	[$32-1,507]
Post and core	[$5-394]	[$5-394]
Core Build-Up]	[$7-349]	[$7-349]
[PROSTHODONTICS- First installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than 1-10 years old. (See *Tooth Missing But Not Replaced Rule*.) Replacement of existing bridges or dentures is limited to 1 every 1-10 years. (See *Replacement Rule*.)		
Bridge Abutments (See Inlays and Crowns)		
Pontics		
Base metal (full cast)	[$20-1,259]	[$20-1,259]
Noble metal (full cast)	[$20-1,246]	[$20-1,246]
Porcelain with noble metal	[$46-1,498]	[$46-1,468]
Porcelain with base metal	[$46-1,098]	[$46-1,098]
Resin with noble metal	[$37-1,592]	[$37-1,592]
Resin with base metal	[$37-1,551]	[$37-1,551]
Removable Bridge (unilateral)		
One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics	[$10-942]	[$10-942]
Dentures and Partials (Fees for dentures and partial dentures include relines, rebases and adjustments within [6-36] months after installation. Fees for relines and rebases include adjustments within [6-36] months after installation. Specialized techniques and characterizations are not eligible.)		
Complete upper denture	[$66-1,706]	[$66-1,706]
Complete lower denture	[$66-1,706]	[$66-1,706]
Partial upper or lower, resin base (including any conventional clasps, rests and teeth)	[$75-1,595]	[$75-1,595]
Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)	[$75-1,633]	[$75-1,633]
Stress breakers	[$7-399]	[$7-399]
Interim partial denture (stayplate), anterior only	[$15-722]	[$15-722]
Office reline	[$7-440]	[$7-440]
Laboratory reline	[$17-432]	[$17-432]
Special tissue conditioning, per denture	[$5-250]	[$5-250]
Rebase, per denture	[$24-638]	[$24-638]
Adjustment to denture more than [6-36] months after installation	[$2-135]	[$2-135]
Full and partial denture repairs	[$1-227]	[$1-227]

Aetna Life Insurance Company
[Schedule of Dental Care Benefits]

Broken dentures, no teeth involved	[$1-207] [**NETWORK**]	[$1-207] [**OUT-OF-NETWORK**]
	Maximum Allowable Amount	
Repair cast framework	[$1-207]	[$1-207]
Replacing missing or broken teeth, each tooth	[$1-194]	[$1-194]
Adding teeth to existing partial denture		
Each tooth	[$12-219]	[$12-219]
Each clasp	[$15-230]	[$15-230]
Repairs: crowns and bridges	[$1-327]	[$1-327]
Occlusal guard (for bruxism only) (limited to 1-4 every 1-5 years)]	[$15-641]	[$15-641]
[IMPLANTS (limited to 1-10 teeth, [every 1-5 years] [per lifetime])]	[$5-2,156]	[$5-2,156]
[SPACE MAINTAINERS Only when needed to preserve space resulting from premature loss of decidous teeth. (Includes all adjustments within 6 months after installation**.)**		
Fixed (unilateral or bilateral)	[$17-673]	[$17-673]
Removable (unilateral or bilateral)	[$20-943]	[$20-943]
Removable inhibiting appliance to correct thumbsucking	[$30-943]	[$30-943]
Fixed or cemented inhibiting appliance to correct thumb sucking]	[$30-673]	[$30-673]
[GENERAL ANESTHESIA AND INTRAVENOUS SEDATION (only when provided in conjunction with a covered surgical procedure)]	[$2-464]	[$2-464]
[ORTHODONTICS		
Interceptive orthodontic treatment	[$250-2,400]	[$250-2,400]
Limited orthodontic treatment	[$250-1,980]	[$250-1,980]
Comprehensive orthodontic treatment of adolescent dentition	[$250-6,750]	[$250-6,750]
Comprehensive orthodontic treatment of adult dentition	[$250-7,350]	[$250-7,350]
Post treatment stabilization]	[$10-684]	[$10-684]
[VISITS AND EXAMS		
Adjunctive pre-diagnostic tests (limited to 2-6 visits every year)]	[$8-71]	[$8-71]

[Policyholder: ABC Company
Group Policy Number: 123456
Effective Date: January 1, 2004]

Aetna Life Insurance Company
[Schedule of Benefits]

THIS SCHEDULE APPLIES TO SERVICES PROVIDED BY [NETWORK] PROVIDERS	
PRIMARY CARE DENTIST SERVICES	
[**VISITS AND EXAMS**	**Copayment Amount**
Oral examination (limited to total of 2-6 visits per year)	
Comprehensive	$0-40
Periodic	$0-35
Limited - problem focused	$0-40
Detailed and extensive - problem focused	$0-50
Re-evaluation - limited, problem focused	$0-40
Emergency palliative treatment	$0-95
Prophylaxis (cleaning), (limited to 2-6 treatments per year)	
Adult	$0-60
Child	$0-40
Topical application of fluoride (limited to 1-4 treatment per year and to covered	
persons under age 14-30)	$0-40
Oral hygiene instruction	$0-35
Sealants, per tooth (limited to 1-2 application every 1-5 years for permanent	
bicuspids and molars and to covered persons under age 14-30)	$0-45
Pulp vitality test	$0-40
Consultation	$0-100
Diagnostic casts	$0-45
Adjunctive pre-diagnostic tests (limited to total of 2-6 visits per year)	$0-160]
[**X-RAYS AND PATHOLOGY**	
Bitewing x-rays (limited to 1-4 set per year)	$0-35
Entire dental series, including bitewings, or panoramic film, limited to 1-8	
set every 1-5 years)	$0-60
Vertical bitewing X-rays (limited to 1-4 sets every 1-5 years)	$0-60
Periapical x-ray (single films up to 13-25 films)	$0-30
Intra-oral, occlusal view, maxillary or mandibular	$0-40
Extra-oral upper or lower jaw	$0-50
Biopsy and histopathologic examination of oral tissue	$0-195]
[ENDODONTICS	
Pulp cap	$0-95
Pulpotomy	$0-145
Root canal therapy, including necessary x-rays	
Anterior	$0-625
Bicuspid	$0-750]

Aetna Life Insurance Company
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[RESTORATIONS AND REPAIRS (**Copayments** for crowns and pontics are per unit.) *There will be an additional patient charge for the actual cost of high noble metal ("gold") when used for services shown.	**Copayment Amount**
Amalgam restoration	
1 surface	$0-115
2 surfaces	$0-145
3 surfaces	$0-185
4 or more surfaces	$0-215
Resin-based composite restoration [(other than for molars)]	
1 surface	$0-140
2 surfaces	$0-165
3 surfaces	$0-200
4 or more surfaces or incisal angle	$0-240
Retention pins	$0-65
Stainless steel crowns, prefabricated, primary tooth	$0-200
Stainless steel crowns, prefabricated, permanent tooth	$0-200
Recementing inlays or crowns	$0-45
Recementing bridges	$0-115
Tissue conditioning for dentures	$0-145
Sedative filling	$0-90
Inlays and Onlays, metallic*	$0-1020
Crowns	
Porcelain	$0-1020
Porcelain with metal (includes abutments)*	$0-1020
Metallic (full cast) (includes abutments)*	$0-1020
Metallic (3/4 cast)*	$0-1020
Cast post and core*	$0-360
Prefabricated post and core	$0-300
Core buildup including pins	$0-240
Pontics	
Metallic (full cast)*	$0-1020
Porcelain with metal*	$0-1020
Full mouth rehabilitation, per unit (This means 6 or more covered units of	
crowns and/or pontics under one treatment plan.)	$0-275]

Aetna Life Insurance Company
[Schedule of Benefits]

	Copayment Amount
[Dentures and Partials - (Includes relines, rebases and adjustments	
within 6-36 months after installation. Adjustments within first 6-36 months	
are limited to four.)	
Complete, upper or lower	$0-1020
Partial, upper or lower	
Resin base	$0-1020
Cast metal base	$0-1215
Immediate, upper or lower (does not include charge for reline)	$0-1215
Adjust complete denture, upper or lower	$0-70
Adjust partial denture, upper or lower	$0-70
Repair broken acrylic, complete denture, upper or lower	$0-125
Replace one tooth on complete denture	$0-90
Repair acrylic, cast frame, broken clasp	$0-145
Replace broken tooth, partial	$0-125
Add tooth to existing partial denture	$0-125
Add clasp to existing partial	$0-135
Rebase, complete denture, upper or lower	$0-400
Rebase, partial denture, upper or lower	$0-400
Reline, complete denture, upper or lower (chairside)	$0-215
Reline, partial denture, upper or lower (chairside)	$0-215
Reline, complete denture, upper or lower (laboratory)	$0-285
Reline, partial denture, upper or lower (laboratory)	$0-285
Interim partial denture, upper or lower (stayplate), anterior only	$0-440]
[**PERIODONTICS**	
Scaling and root planning, per quadrant (limited to 1-4 separate quadrants every 1-2 years)	$0-250
Scaling and root planning- 1 to 3 teeth per quadrant (limited to 1-4 per site every 1-2 years)	$0-70
Periodontal maintenance procedures following surgical therapy	
(limited to 1-4 per year)	$0-125
Occlusal guard (for bruxism only), limited to 1-4 every 1-5 years	$0-430
Full mouth debridement (limited to 1-4 per lifetime)	$0-220
Local delivery of antimicrobial agents	$0-220]
[ORAL SURGERY - Includes local anesthetics and routine post-operative care	
Extraction- exposed root or erupted tooth	$0-135
Surgical removal of erupted tooth	$0-245
Surgical removal of impacted tooth (soft tissue)	$0-315
Incision and drainage of intraoral abscess	$0-156
Surgical exposure of impacted or unerupted tooth to aid eruption	$0-400
Root removal - exposed root	$0-156
Brush biopsy	$0-140]

Aetna Life Insurance Company
[Schedule of Benefits]

[SPACE MAINTAINERS –(only when needed to preserve space resulting from premature loss of deciduous teeth) Includes all adjustments within six months after installation	**Copayment Amount**
Fixed	$0-400
Removable	$0-6250
Recement space maintainer	$0-40]
[NUTRITIONAL COUNSELING and TOBACCO COUNSELING (limited to nutritional counseling for the control of dental disease and tobacco counseling for the control and prevention of oral disease)	$0-68]
[EXTERNAL BLEACHING – [1-6 arches] [every 1-3 years] [per lifetime]	$0-999]

Aetna Life Insurance Company
[Schedule of Benefits]

SPECIALTY SERVICES	
	Copayment Amount
[ENDODONTICS - Includes local anesthetics where necessary	
Apicoectomy/periradicular surgery	
Anterior	$0-563
Bicuspid, first root	$0-615
Molar, first root	$0-900
Each additional root	$0-275
Retrograde filling, per root	$0-150
Root amputation, per root	$0-330
Molar root canal therapy	$0-900]
[ORAL SURGERY-Includes local anesthetics where necessary and post-operative care	
Surgical removal of root tip, root recovery	$0-90
Frenectomy	$0-400
Alveoplasty in conjunction with extractions - per quadrant	$0-240
Alveoplasty not in conjunction with extractions - per quadrant	$0-220
Surgical removal of impacted tooth	
Partially bony	$0-400
Completely bony	$0-470
Completely bony with unusual surgical complications	$0-515]
[**IMPLANTS**-limited to 1-10 teeth, [every 1-5 years] [per lifetime]	$0-2,750]
[PERIODONTICS	
Gingivectomy or gingivoplasty - per quadrant, limited to 1-4	
per quadrant every 1-5 years	$0-470
Gingivectomy or gingivoplasty - per tooth, limited to 1-4	
per site every 1-5 years	$0-125
Gingival flap procedure - per quadrant (limited to 1-2 quadrant every 1-3 years)	$0-415
Gingival flap procedure- 1-3 teeth per quadrant (limited to 1-2 per site every 1-3 years)	$0-250
Occlusal adjustment (other than with an appliance or restoration)	
Limited	$0-95
Complete	$0-275
Osseous surgery (including flap entry and closure) - per quadrant, limited	
to 1-4 per quadrant every 1-5 years	$0-865
Clinical Crown Lengthening – Hard Tissue	$0-320
Bone grafts – first site in quadrant (limited to 1-4 per lifetime)	$0-750
Bone grafts - each additional site in quadrant (limited to 1-4 per lifetime)	$0-500]
[ANESTHESIA (only when provided in conjunction with	
another covered surgical procedure**)**	
Deep sedation/General anesthesia - first 30 minutes	$0-715
Deep sedation/General anesthesia - each additional 15 minutes	$0-400
Intravenous conscious sedation/Analgesia – first 30 minutes	$0-715
Intravenous conscious sedation/Analgesia – each additional 15 minutes	$0-400]

Aetna Life Insurance Company
[Schedule of Benefits]

[ORTHODONTICS	
Orthodontic screening exam (when no Orthodontic Procedure is performed)	$0-75
Orthodontic diagnostic records	$0-400
Comprehensive orthodontic treatment of adolescent and adult dentition	$0-5,000
Orthodontic retention	$0-785]

[Policyholder: ABC Company
Group Policy Number: 123456
Effective Date: January 1, 2004]

Aetna Life Insurance Company
[Schedule of Benefits]

THIS SCHEDULE APPLIES TO SERVICES PROVIDED BY [OUT-OF-NETWORK] PROVIDERS	
PRIMARY SERVICES	
	Amount Payable by Aetna
[VISITS AND EXAMS	
Office visit for oral examination (limited to 2-6 visits per year)	$12-36
Emergency palliative treatment	$12-36
Prophylaxis (cleaning) (limited to 2-6 treatments per year)	
Adult	$26-78
Child	$14-42
Topical application of fluoride (limited to 1-4 treatments per year and to	
covered persons under age 14-30)	$16-48
Oral hygiene instruction	$12-36
Sealants; per tooth (limited to 1-2 application every 1-5 years for permanent bicuspids and molars and to covered persons under age 14-30)	$10-30
Pulp vitality test	$8-24]
[X-RAYS AND PATHOLOGY	
Bitewing x-rays (limited to 1-4 set per year)	$8-24
Entire dental series; including bitewings; or panoramic film (limited to 1-8 set every 1-5 years)	$14-42
Vertical bitewing x-rays (limited to 1-4 set every 1-5 years)	$12-36
Periapical x-rays (single films, up to 13-25 films)	$6-18
Intra-oral; occlusal view; maxillary or mandibular	$8-24
Extra-oral upper or lower jaw	$12-36
Biopsy and histopathologic examination of oral tissue	$27-81]

Aetna Life Insurance Company
[Schedule of Benefits]

	Amount Payable by Aetna
[ENDODONTICS	
Pulp cap	$3-9
Pulpotomy	$27-81
Surgical exposure for rubber dam isolation	$26-78
Root canal therapy; including necessary x-rays	
Anterior	$80-240
Bicuspid	$96-288]
[RESTORATIONS AND REPAIRS	
Amalgam restoration	
1 surface	$12-36
2 surfaces	$16-48
3 surfaces	$24-72
4 or more surfaces	$26-78
Resin-based composite restoration [(other than for molars)]	
1 surface	$12-36
2 surfaces	$16-48
3 surfaces	$26-78
4 or more surfaces or incisal angle	$30-90
Retention pins	$14-42
Stainless steel crowns	$26-78
Prefabricated resin crowns (excluding temporary crowns)	$60-180
Recementing inlays; crowns; bridges; space maintainers	$16-48
Tissue conditioning for dentures	$26-78]
[PERIODONTICS	
Scaling and root planing (limited to 1-4 separate quadrants every 1-2 years)	$40-120
Periodontal maintenance procedures following surgical therapy (limited to 1-4 per year)	$40-120]
[ORAL SURGERY - Includes local anesthetics and routine post-operative care	
Extraction- exposed root or erupted tooth	$27-81
Surgical removal of erupted tooth	$32-96
Surgical removal of impacted tooth (soft tissue)	$40-120
Excision of hyperplastic tissue	$32-96
Excision of pericoronal gingival	$40-120
Incision and drainage of abscess	$20-60
Crown exposure to aid eruption	$26-78
Removal of foreign body from soft tissue	$20-60
Suture of soft tissue injury	$20-60]

Aetna Life Insurance Company
[Schedule of Benefits]

[NUTRITIONAL COUNSELING and TOBACCO COUNSELING (limited to nutritional counseling for the control of dental disease and tobacco counseling for the control and prevention of oral disease)	$12-36]
[EXTERNAL BLEACHING – per arch	$15-45]

Aetna Life Insurance Company
[Schedule of Benefits]

	Amount Payable by Aetna
[RESTORATIONS	
Inlays	
1 surface	$60-180
2 surfaces	$80-240
3 or more surfaces	$80-240
Onlays	
2 surfaces	$80-240
3 surfaces	$80-240
4 or more surfaces	$80-240
Crowns (including build-ups when necessary)	$120-360
Resin	$120-360
Resin with noble metal	$120-360
Resin with base metal	$120-360
Porcelain	$120-360
Porcelain with noble metal	$120-360
Porcelain with base metal	$120-360
Base metal (full cast)	$120-360
Noble metal (full cast)	$120-360
Metallic (3/4 cast)	$27-81
Post and core	$27-81
Pontics	
Base metal (full cast)	$20-60
Noble metal (full cast)	$20-60
Porcelain with noble metal	$20-60
Porcelain with base metal	$20-60
Resin with noble metal	$20-60
Resin with base metal	$20-60]
[Dentures and Partials - (includes relines; rebases and adjustments within 6-36 months after installation)	
Full (Upper or Lower)	$120-360
Partial	$120-360
Stress breakers (per unit)	$40-120
Interim partial denture; (stayplates); anterior only	$40-120
Crown and bridge repairs	$27-81
Adding teeth to an existing denture	$40-120
Full and partial denture repairs	$27-81

Aetna Life Insurance Company
[Schedule of Benefits]

	Amount Payable by Aetna
Relining/rebasing dentures (includes adjustments within 6-36 months	
after installation)	$40-120
Occlusal guard (for bruxism only); (limited to 1-4 every 1-5 years)	$40-120]
[**SPACE MAINTAINERS** - Includes all adjustments within six months after installation	
Fixed; band type	$40-120
Removable acrylic with round wire clasp	$32-96
Removable appliance to correct habits	$32-96
Fixed or cemented appliance to correct habits	$40-120]
[**VISITS AND EXAMS**	
Adjunctive pre-diagnostic tests (limited to total of 2-6 visits per year)	$9-27]
[**PERIODONTICS**	
Full mouth debridement (limited to 1-4 per lifetime)	$40-120
Local delivery of antimicrobial agents	$20-60]
[**ORAL SURGERY**	
Brush Biopsy	$9-27]
[**IMPLANTS**-limited to 1-10 teeth, [every 1-5 years] [per lifetime]]	$150-450]

Aetna Life Insurance Company
[Schedule of Benefits]

SPECIALTY SERVICES	
	Amount Payable by Aetna
[ENDODONTICS - Includes local anesthetics where necessary.	
Apexification/recalcification - per visit	$32-96
Apicoectomy	
First root	$60-180
Each additional root	$40-120
Retrograde Filling	$14-42
Root Amputation	$27-81
Hemisection	$27-81]
[ORAL SURGERY - Includes local anesthetics where necessary and post-operative care	
Removal of residual root	$27-81
Removal of odontogenic cyst	$40-120
Closure of oral fistula	$48-144
Removal of foreign body from bone	$20-60
Sequestrectomy	$20-60
Frenectomy	$40-120
Transplantation of tooth or tooth bud	$48-144
Alveoplasty in conjunction with extractions - per quadrant	$27-81
Alveoplasty not in conjunction with extractions - per quadrant	$40-120
Removal of exostosis	$60-180
Sialolithotomy; removal of salivary calculus	$36-108
Closure of salivary fistula	$36-108]
[PERIODONTICS	
Gingivectomy or gingivoplasty - per quadrant (limited to 1-4 quadrant; every 1-5 years)	$40-120
Gingivectomy or gingivoplasty - per tooth (limited to 1-4 per site; every 1-5 years	$20-60
Gingival flap procedure - per quadrant	$60-180
Occlusal adjustment (other than with an appliance or by restoration)	
Limited	$20-60
Entire mouth	$40-120
Clinical Crown Lengthening - Hard Tissue	$20-60]

Aetna Life Insurance Company
[Schedule of Benefits]

	Amount Payable by Aetna
[ENDODONTICS - Includes local anesthetics where necessary	
Complex Molar Root Canal Therapy	$120-360]
[INTRAVENOUS SEDATION AND GENERAL ANESTHESIA (only when medically necessary and provided in conjunction with another covered procedure**)** – per 15-minute segment	$20-60]
[ORAL SURGERY - Includes local anesthetics where necessary and post-operative care	
Surgical removal of impacted tooth	
Partially Bony	$53-159
Completely Bony	$60-180
Completely Bony with unusual surgical complications	$64-192]
[PERIODONTICS	
Osseous surgery (including flap entry and closure) - per quadrant(limited to	
1-4 per quadrant; every 1-5 years	$80-240
Bone grafts – first site in quadrant (limited to 1-4 per lifetime)	$40-120
Bone grafts – each additional site in quadrant (limited to 1-4 per lifetime)	$25-75]
[ORTHODONTICS	
Comprehensive orthodontic treatment of adolescent and adult dentition	
Post Treatment Stabilization	
Lifetime Maximum:	$400-1,200**]**

[Policyholder: ABC Company
Group Policy Number: 123456
Effective Date: January 1, 2004]

Aetna Life Insurance Company
[Managed Dental Coinsurance Plan] [Comprehensive Dental Expense Insurance]
[Schedule of Benefits]

PLAN FEATURES

Dental Care Schedule

Primary Care Dentists and Specialty Care Dentists ([Network] Dental Provider) Covered Expenses

Coverage is provided only for services shown in the Dental Care Schedule (see the *What the Plan Covers* section). This dental expense coverage is segmented into four service types. The **copayments** shown below apply**.** The "amounts payable", shown on the list, will not apply when services are provided by **[network] providers**.

[**Office Visit Copayment:** $2-25 per visit.]

Dental Care Schedule	**Copayment Amounts**	
Service Type	**Primary Care Services**	**Specialty Care Services**
[Type A Expenses	0%-30%	Not Applicable
Type B Expenses	0%-70%	0%-70%
Type C Expenses	0%-70%	0%-70%
Orthodontic Expenses	[0%-70%] [$0-5,000]	[0%-70%] [$0-5,000]]

Deductible Amount: [$25-200] [The deductible does not apply to orthodontic services.]]

[ORTHODONTICS	
Orthodontic screening exam (when no **orthodontic treatment** is performed)	$0-60
Orthodontic diagnostic records	$0-315
Comprehensive orthodontic treatment of adolescent and adult dentition	$0-4,000
Orthodontic retention	$0-625]

[Orthodontic Lifetime Maximum: 24 months of active treatment plus 24 months of retention.] [$250-5,000]

[Dental Emergency Maximum: $75–1,000]

[Out-of-Network] Dental Provider Covered Expenses

Coverage is provided only for services shown in the list of Covered Dental Services. The "amount payable" applies only to services and supplies provided by [**out-of-network] providers**. The amounts shown are not **copayments**, they are the maximum charges eligible for coverage under your plan for the service listed.]

Aetna Life Insurance Company
[Schedule of Benefits]

List of Covered Dental Services

If:

- A charge is made for an unlisted service given for the dental care of a specific condition; and
- The list includes one or more services that, under standard practices, are separately suitable for the dental care of that condition, then the charge will be considered to have been made for a service that would have produced a professionally acceptable result, as determined by **Aetna**.

Aetna Life Insurance Company
[Schedule of Benefits]

THIS SCHEDULE APPLIES TO SERVICES PROVIDED BY [OUT-OF-NETWORK] PROVIDERS	
PRIMARY CARE SERVICES	
SCHEDULE	
[**TYPE A EXPENSES]**	
	Amount Payable by Aetna
[**VISITS AND EXAMS**	
Office visit for oral examination (limited to 2-6 visits per year)	$12-36
Emergency palliative treatment	$12-36
Prophylaxis (cleaning) (limited to 2-6 treatments per year)	
Adult	$26-78
Child	$14-42
Topical application of fluoride (limited to 1-4 treatment per year and to covered persons under age 14-30)	$16-48
Oral hygiene instruction	$12-36
Sealants; per tooth (limited to 1-2 application every 1-5 years for permanent molars and to covered persons under age 14-30)	$10-30
Pulp vitality test	$8-24
Consultation	$12-36
Diagnostic casts	$20-60]
[**X-RAYS AND PATHOLOGY**	
Bitewing x-rays (limited to 1-4 set per year)	$8-24
Entire dental series; including bitewings; or panoramic film (limited to 1-8 sets every 1-5 years)	$14-42
Vertical bitewing x-rays (limited to 1-4 set every 1-5 years)	$12-36
Periapical x-rays	$6-18
Intra-oral; occlusal view; maxillary or mandibular	$8-24
Extra-oral upper or lower jaw	$12-36
Biopsy and histopathologic examination of oral tissue	$27-81]
[**SPACE MAINTAINERS** - Includes all adjustments within six months after installation.	
Fixed; band type	$40-120
Removable acrylic with round wire clasp	$32-96
Recement space maintainer	$10-30]

Aetna Life Insurance Company
[Schedule of Benefits]

[TYPE B EXPENSES]	
[ENDODONTICS	**Amount Payable by Aetna**
Pulp cap	$3-9
Pulpotomy	$27-81
Root canal therapy; including necessary x-rays	
Anterior	$80-240
Bicuspid	$96-288]
[RESTORATIONS AND REPAIRS	
Amalgam restoration	
1 surface	$12-36
2 surfaces	$16-48
3 surfaces	$24-72
4 or more surfaces	$26-78
Resin restoration [(other than for molars)]	
1 surface	$12-36
2 surfaces	$16-48
3 surfaces	$26-78
4 or more surfaces or incisal angle	$30-90
Retention pins	$14-42
Sedative filling	$12-36
Stainless steel crowns	$26-78
Prefabricated resin crowns (excluding temporary crowns)	$60-180
Recementing inlays or crowns	$16-48
Recementing bridges	$16-48
Tissue conditioning for dentures	$26-78]
[**PERIODONTICS**	
Emergency treatment (abscess; acute periodontitis; etc.)	$26-78
Subgingival curettage (limited to 1-4 separate quadrants; every 1-2 years)	$40-120
Scaling and root planning (limited to 1-4 separate quadrants every 1-2 years)	$40-120
Periodontal maintenance procedures following surgical therapy (limited to 1-2 per year)	$40-120]

Aetna Life Insurance Company
[Schedule of Benefits]

[TYPE B EXPENSES (Continued)]	
[**ORAL SURGERY** - Includes local anesthetics and routine post-operative care.	**Amount Payable by Aetna**
Extractions; uncomplicated	$27-81
Surgical removal of erupted tooth	$32-96
Surgical removal of impacted tooth (soft tissue)	$40-120
Excision of hyperplastic tissue	$32-96
Excision of pericoronal gingival	$40-120
Incision and drainage of abscess	$20-60
Crown exposure to aid eruption	$26-78
Removal of foreign body from soft tissue	$20-60
Suture of soft tissue injury	$20-60]
[NUTRITIONAL COUNSELING and TOBACCO COUNSELING (limited to nutritional counseling for the control of dental disease and tobacco counseling for the control and prevention of oral disease)	$12-36]

Aetna Life Insurance Company
[Schedule of Benefits]

[TYPE C EXPENSES]	
[**RESTORATIONS**	**Amount Payable by Aetna**
Inlays	
1 surface	$60-180
2 or more surfaces	$80-240
Onlays	
2 surfaces	$80-240
3 or more surfaces	$80-240
Crowns (including build-ups when necessary)	
Resin	$120-360
Resin with noble metal	$120-360
Resin with base metal	$120-360
Porcelain	$120-360
Porcelain with noble metal	$120-360
Porcelain with base metal	$120-360
Base metal (full cast)	$120-360
Noble metal (full cast)	$120-360
Metallic (3/4 cast)	$120-360
Post and core	$27-81
Pontics	
Base metal (full cast)	$20-60
Noble metal (full cast)	$20-60
Porcelain with noble metal	$20-60
Porcelain with base metal	$20-60
Resin with noble metal	$20-60
Resin with base metal	$20-60]
[**Dentures and Partials** - (includes relines; rebases and adjustments within 6-36 months after installation)	
Full (Upper or Lower)	$120-360
Partial	$120-360
Stress breakers (per unit)	$40-120
Interim partial denture; (stayplates); anterior only	$40-120
Crown and bridge repairs	$27-81
Adding teeth to an existing denture	$40-120
Full and partial denture repairs	$27-81
Relining/rebasing dentures (includes adjustments with 6-36 months after installation	$40-120
Occlusal guard (for bruxism only); (limited to 1-4 every 1-5 years)	$40-120]

Aetna Life Insurance Company
[Schedule of Benefits]

[TYPE C EXPENSES - (Continued)]	
[**VISITS AND EXAMS**	**Amount Payable by Aetna**
Adjunctive pre-diagnostic tests (limited to 2-6 visits per year)	$9-27]
[**PERIODONTICS**	
Full mouth debridement (limited to 1-4 per lifetime)	$40-120
Local delivery of antimicrobial agents	$20-60]
[**ORAL SURGERY**	
Brush biopsy	$9-27]
[**IMPLANTS**-limited to 1-10 teeth, [every 1-5 years] [per lifetime]]	$150-450]

Aetna Life Insurance Company
[Schedule of Benefits]

SPECIALTY CARE DENTAL SERVICES	
[TYPE B EXPENSES]	
[ENDODONTICS - Includes local anesthetics where necessary.	**Amount Payable by Aetna**
Apexification/recalcification - per visit	$32-96
Apicoectomy	
First root	$60-180
Each additional root	$40-120
Retrograde Filling	$14-42
Root Amputation	$27-81
Hemisection	$27-81]
[ORAL SURGERY - Includes local anesthetics where necessary and post-operative care.	
Removal of residual root	$27-81
Removal of odontogenic cyst	$40-120
Closure of oral fistula	$48-144
Removal of foreign body from bone	$20-60
Sequestrectomy	$20-60
Frenectomy	$40-120
Transplantation of tooth or tooth bud	$48-144
Alveoplasty in conjunction with extractions - per quadrant	$27-81
Alveoplasty not in conjunction with extractions - per quadrant	$40-120
Removal of exostosis	$60-180
Sialolithotomy; removal of salivary calculus	$36-108
Closure of salivary fistula	$36-108]
[**PERIODONTICS**	
Gingivectomy or gingivoplasty - per quadrant (limited to 1-4 quadrant; every 1-5 years)	$40-120
Gingivectomy or gingivoplasty - per tooth (limited to 1-4 per site; every 1-5 years)	$20-60
Gingival flap procedure - per quadrant	$60-180
Occlusal adjustment (other than with an appliance or by restoration)	
Limited	$20-60
Entire Mouth	$40-120
Clinical Crown Lengthening – Hard Tissue	$20-60]

Aetna Life Insurance Company
[Schedule of Benefits]

[TYPE C EXPENSES]	
[ENDODONTICS - Includes local anesthetics where necessary.	**Amount Payable by Aetna**
Complex Molar Root Canal Therapy	$120-360]
[INTRAVENOUS SEDATION AND GENERAL ANESTHESIA	
- per 15-minute segment.	$20-60]
[ORAL SURGERY - Includes local anesthetics where necessary and post-operative care.	
Surgical removal of impacted tooth	
Partially bony	$53-159
Completely bony	$60-180
Completely bony with unusual surgical complications	$64-192]
[**PERIODONTICS**	
Osseous surgery (including flap entry and closure) - per quadrant (limited to 1-4 per quadrant; every 1-5 years)	$80-240
Bone grafts – first site in quadrant (limited to 1-4 per lifetime)	$40-120
Bone grafts – each additional site in quadrant (limited to 1-4 per lifetime)	$25-75]
[ORTHODONTICS	
Comprehensive orthodontic treatment of adolescent dentition	
Comprehensive orthodontic treatment of adult dentition	
Post Treatment Stabilization	
Lifetime Maximum:	$400-1,200]

Aetna Life Insurance Company
Comprehensive Dental Expense Insurance
[Schedule of Benefits]

APPLIES TO SERVICES PROVIDED BY [NETWORK] PROVIDERS PRIMARY CARE DENTIST SERVICES	
[VISITS AND EXAMS	**Copayment Amount**
Oral examination (limited to total of 2-6 visits per year)	
Comprehensive	$0-30
Periodic	$0-25
Limited - problem focused	$0-30
Detailed and extensive - problem focused	$0-40
Re-evaluation - limited, problem focused	$0-25
Emergency palliative treatment	$0-75
Prophylaxis (cleaning), (limited to 2-6 treatments per year)	
Adult	$0-40
Child	$0-30
Topical application of fluoride (limited to 1-4 treatment per year and to covered	
persons under age 14-30)	$0-30
Oral hygiene instruction	$0-25
Sealants, per tooth (limited to 1-2 application every 1-5 years for permanent	
bicuspids and molars and to covered persons under age 14-30)	$0-30
Pulp vitality test	$0-30
Consultation	$0-80
Diagnostic casts	$0-35
Adjunctive pre-diagnostic tests (limited to total of 2-6 visits per year)	$0-$125]
[X-RAYS AND PATHOLOGY	
Bitewing x-rays (limited to 1-4 set per year)	$0-25
Entire dental series, including bitewings, or panoramic film, limited to 1-8	
sets every 1-5 years)	$0-45
Vertical bitewing x-rays (limited to 1-4 sets every 1-5 years)	$0-45
Periapical x-ray (single films up to 13-25 films)	$0-20
Intra-oral, occlusal view, maxillary or mandibular	$0-30
Extra-oral upper or lower jaw	$0-40
Biopsy and histopathologic examination of oral tissue	$0-155]
[ENDODONTICS	
Pulp cap	$0-75
Pulpotomy	$0-115
Root canal therapy, including necessary x-rays	
Anterior	$0-500
Bicuspid	$0-600]

Aetna Life Insurance Company
Comprehensive Dental Expense Insurance
[Schedule of Benefits]

[RESTORATIONS AND REPAIRS (**Copayments** for crowns and pontics are per unit.) *There will be an additional patient charge for the actual cost of high noble metal ("gold") when used for services shown.	
	Copayment Amount
Amalgam restoration	
1 surface	$0-90
2 surfaces	$0-115
3 surfaces	$0-145
4 or more surfaces	$0-170
Resin-based composite restoration [(other than for molars)]	
1 surface	$0-110
2 surfaces	$0-130
3 surfaces	$0-160
4 or more surfaces or incisal angle	$0-190
Retention pins	$0-50
Stainless steel crowns, prefabricated, primary tooth	$0-155
Stainless steel crowns, prefabricated, permanent tooth	$0-155
Recementing inlays or crowns	$0-35
Recementing bridges	$0-90
Tissue conditioning for dentures	$0-115
Sedative filling	$0-70
Inlays and Onlays, metallic*	$0-815
Crowns	
Porcelain	$0-815
Porcelain with metal (includes abutments)*	$0-815
Metallic (full cast) (includes abutments)*	$0-815
Metallic (3/4 cast)*	$0-815
Cast post and core*	$0-285
Prefabricated post and core	$0-235
Core buildup including pins	$0-190
Pontics	
Metallic (full cast)*	$0-815
Porcelain with metal*	$0-815
Full mouth rehabilitation, per unit (This means 6 or more covered units of	
crowns and/or pontics under one treatment plan.)	$0-220]

Aetna Life Insurance Company
Comprehensive Dental Expense Insurance
[Schedule of Benefits]

	Copayment Amount
[Dentures and Partials - (Includes relines, rebases and adjustments	
within 6-36 months after installation. Adjustments within first 6-36 months	
are limited to four.)	
Complete, upper or lower	$0-815
Partial, upper or lower	
Resin base	$0-815
Cast metal base	$0-970
Immediate, upper or lower (does not include charge for reline)	$0-970
Adjust complete denture, upper or lower	$0-55
Adjust partial denture, upper or lower	$0-55
Repair broken acrylic, complete denture, upper or lower	$0-100
Replace one tooth on complete denture	$0-70
Repair acrylic, cast frame, broken clasp	$0-115
Replace broken tooth, partial	$0-100
Add tooth to existing partial denture	$0-100
Add clasp to existing partial	$0-105
Rebase, complete denture, upper or lower	$0-315
Rebase, partial denture, upper or lower	$0-315
Reline, complete denture, upper or lower (chairside)	$0-170
Reline, partial denture, upper or lower (chairside)	$0-170
Reline, complete denture, upper or lower (laboratory)	$0-225
Reline, partial denture, upper or lower (laboratory)	$0-225
Interim partial denture, upper or lower (stayplate), anterior only	$0-350]
[PERIODONTICS	
Scaling and root planning, per quadrant (limited to 1-4 separate quadrants every 1-2 years)	$0-200
Scaling and root planning- 1 to 3 teeth per quadrant (limited to 1-4 per site every 1-2 years)	$0-55
Periodontal maintenance procedures following surgical therapy	
(limited to 1-4 per year)	$0-100
Occlusal guard (for bruxism only), limited to 1-4 every 1-5 years	$0-345
Full mouth debridement (limited to 1-4 per lifetime)	$0-175
Local delivery of antimicrobial agents	$0-175]
[ORAL SURGERY - Includes local anesthetics and routine post-operative care	
Extraction- exposed root or erupted tooth	$0-105
Surgical removal of erupted tooth	$0-195
Surgical removal of impacted tooth (soft tissue)	$0-250
Incision and drainage of intraoral abscess	$0-125
Surgical exposure of impacted or unerupted tooth to aid eruption	$0-320
Root removal - exposed root	$0-125
Brush biopsy	$0-110]

Aetna Life Insurance Company
Comprehensive Dental Expense Insurance
[Schedule of Benefits]

	Copayment Amount
[SPACE MAINTAINERS –(only when needed to preserve space resulting from premature loss of deciduous teeth) Includes all adjustments within six months after installation	
Fixed	$0-315
Removable	$0-500
Recement space maintainer	$0-30]
[NUTRITIONAL COUNSELING and TOBACCO COUNSELING (limited to nutritional counseling for the control of dental disease and tobacco counseling for the control and prevention of oral disease)	$0-68]
[EXTERNAL BLEACHING – [1-6 arches] [every 1-3 years] [per lifetime]	$0-999]
[SPECIALTY SERVICES **The following specialty services will be covered when provided by a Primary Care Dentist.]**	
[ENDODONTICS - Includes local anesthetics where necessary	
Apicoectomy/periradicular surgery	
Anterior	$0-450
Bicuspid, first root	$0-490
Molar, first root	$0-720
Each additional root	$0-220
Retrograde filling, per root	$0-120
Root amputation, per root	$0-265
Molar root canal therapy	$0-720]
[ORAL SURGERY - Includes local anesthetics where necessary and post-operative care	
Alveoplasty in conjunction with extractions - per quadrant	$0-190
Alveoplasty not in conjunction with extractions - per quadrant	$0-175
Surgical removal of impacted tooth	
Partially bony	$0-315
Completely bony	$0-375
Completely bony with unusual surgical complications	$0-410]

Aetna Life Insurance Company
Comprehensive Dental Expense Insurance
[Schedule of Benefits]

	Copayment Amount
[PERIODONTICS	
Gingivectomy or gingivoplasty - per quadrant, limited to 1-2	
per quadrant, every 1-5 years	$0-375
Gingivectomy or gingivoplasty - per tooth, limited to 1-2	
per site, every 1-5 years	$0-100
Gingival flap procedure – per quadrant (limited to 1-2 quadrant every 1-3 years)	$0-325
Gingival flap procedure- 1-3 teeth one per quadrant (limited to 1-2 per site every 1-3 years)	$0-200
Occlusal adjustment (other than with an appliance or restoration)	
Complete	$0-220
Osseous surgery (including flap entry and closure) - per quadrant, limited	
to 1-4 per quadrant, every 1-5 years	$0-690
Clinical Crown Lengthening – Hard Tissue	$0-255]
[ANESTHESIA (only when provided in conjunction with another covered procedure)	
Deep sedation/General anesthesia - first 30 minutes	$0-565
Deep sedation/General anesthesia - each additional 15 minutes	$0-315
Intravenous conscious sedation/Analgesia – first 30 minutes	$0-565
Intravenous conscious sedation/Analgesia – each additional 15 minutes	$0-315]
[**IMPLANTS**-limited to 1-10 teeth, [every 1-5 years] [lifetime]]	$0-2,750]
[SPECIALTY SERVICES **The following specialty services will be covered when provided by a Specialist Dentist.]**	
[ORAL SURGERY - Includes local anesthetics where necessary and post-operative care	
Surgical removal of root tip, root recovery	$0-325
Frenectomy	$0-70]
[PERIODONTICS	
Occlusal adjustment (other than with an appliance or restoration)	
Limited	$0-75
Bone grafts – first site in quadrant (limited to 1-4 per lifetime)	$0-600
Bone grafts – each additional site in quadrant (limited to 1-4 per lifetime)	$0-400]
[ORTHODONTICS	
Orthodontic screening exam (when no orthodontic procedure is performed)	$0-60
Orthodontic diagnostic records	$0-315
Comprehensive orthodontic treatment of [adolescent and adult] dentition	$0-4,000
Orthodontic retention	$0-625]

About the [Alternate] PPO Dental [Expense Insurance Plan]

The [alternate] plan is a Preferred Provider Organization (PPO) Dental [Expense Insurance Plan] that covers a [wide] [limited] range of dental services and supplies. You can visit the **dental provider** of your choice when you need dental care.

You can choose a **dental provider** who is in the dental network. You may pay less out of your own pocket when you choose a [**network**] **provider**.

You have the freedom to choose a **dental provider** who is not in the dental network. You may pay more out of your own pocket when you choose an [**out-of-network**] **provider**.

The [*Schedule of Benefits*] shows you how the Plan's level of coverage is different for [**network**] **services and supplies** and [**out-of-network**] **services and supplies**.

The Choice Is Yours

You have a choice each time you need dental care:

Using [Network] Providers

- You will receive the Plan's higher level of coverage when your care is provided by a [**network**] **provider**.
- [The plan begins to pay benefits after you satisfy a **deductible**.]
- [You share the cost of covered services and supplies by paying a portion of certain expenses (your **coinsurance**).] [**Network] providers** have agreed to provide covered services and supplies at a **negotiated charge**. [*However, if the **negotiated charge** for a **network provider** is more than the maximum allowable amount for a service and supply, then you will be responsible for any difference between the **negotiated charge** and the maximum allowable amount in addition to any other cost-sharing required of you by this Plan such as **coinsurance**, **deductibles** and **copays**.*] Your **coinsurance** is based on the **negotiated charge**. In no event will you have to pay any amounts above the **negotiated charge** for a covered service or supply.
- [If the **negotiated charge** is more than the maximum allowable amount, the difference between them, which you are responsible to pay, does not count toward any **deductible** or **coinsurance limit** under this Plan.]
- You will not have to submit dental claims for treatment received from [**network**] **providers**. Your [**network**] **provider** will take care of claim submission. [**Aetna** will directly pay the **network provider** less any cost sharing required by you.] You will be responsible for **deductibles, coinsurance** and **copayments**, if any.
- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards any **deductible, copayment, coinsurance**, or other non-**covered expenses** you have incurred. [You may elect to receive this notification by e-mail, or through the mail.] Call or e-mail Member Services if you have questions regarding your statement.

Availability of Providers

Aetna cannot guarantee the availability or continued participation of a particular **provider**. Either **Aetna** or any [**network**] **provider** may terminate the **provider** contract or limit the number of patients accepted in a practice.

Using [Out-of-Network] Providers

You can obtain dental care from **dental providers** who are not in the network. The plan covers [**out-of-network] services and supplies**, but your expenses will generally be higher.

[Out-of-network] **providers** have not agreed to accept the **negotiated charge** and may balance bill you for charges over the amount **Aetna** pays under the plan. **Deductibles** and **coinsurance** are usually higher when you utilize [**out-of network**] **providers.** Except for emergency services, **Aetna** will only pay up to the **recognized** [**charge**].

[You must satisfy a **deductible** before the plan begins to pay benefits.]

You share the cost of covered services and supplies by paying a portion of certain expenses (your **coinsurance**).

[For **covered expenses** that are subject to a maximum allowable amount, if the charge of an **out-of-network provider** is more than the maximum allowable amount for a service and supply, then you will also be responsible for any difference between the billed charge and the maximum allowable amount. *This means that you will have to pay to the provider any amount above the maximum allowable amount for that service and supply in addition to any other cost-sharing required of you by this Plan such as **coinsurance** and **deductibles**.* If the billed charge is more than the maximum allowable amount, *you are responsible for the difference* and that difference does not count toward any **deductible** or **coinsurance limit** under this Plan.]

[If your [**out-of-network] provider** charges more than the [**recognized charge]**, you will be responsible for any expenses incurred above the [**recognized charge]**. [That excess amount does not apply toward your [**coinsurance limit]**.] The [**recognized charge]** is the maximum amount **Aetna** will pay for a **covered expense** from an [**out-of-network] provider**.

You must file a claim to receive reimbursement from the plan.]

Important Reminder

Refer to the [*Schedule of Benefits*] for details about any [**deductibles**, **copays**, **coinsurance**] and maximums that apply. [There is a separate **deductible** and benefit maximum that applies to **orthodontic treatment**.]

[[Limited] [Comprehensive] [PPO] Dental Expense Insurance Plan]

[In addition to the **covered expenses** listed under [Type A, Type B and Type C] below, the following additional dental expenses will be considered **covered expenses** if you [and your covered dependent] and have at least one of the following conditions:

- [Pregnancy;
- Coronary artery disease/cardiovascular disease;
- Cerebrovascular disease; or
- Diabetes]

Additional Covered Dental Expenses (limited to one additional per year)

- [Prophylaxis (cleaning);
- Scaling and root planing, (4 or more teeth), per quadrant;
- Scaling and root planing (limited to 1-3 teeth), per quadrant;
- Full mouth debridement;
- Periodontal maintenance; and
- Localized delivery of antimicrobial agents. (Not covered for pregnancy.)]

Payment of Benefits

The Plan **coinsurance** applied to the additional covered dental expenses above will be [100% for network expenses and 50-100% for out-of-network expenses.] [These additional benefits will not be subject to any frequency limits except as shown above or any calendar year maximum].]

[The **copayment** and **deductible** will be waived for the additional covered dental expenses above and will not be subject to any frequency limits except as shown above or any calendar year maximum].]

Aetna will reimburse the provider directly, or you may pay the provider directly and then submit a claim for reimbursement for **covered expenses**.

Important Reminder

The [**copays**, **deductible**,] **coinsurance**, and maximums that apply to each type of dental care are shown in the [*Schedule of Benefits*].

[You may receive services and supplies from **network** and **out-of-network providers**. Services and supplies given by a **network provider** are covered at the network level of benefits shown in the *Schedule of Benefits*. Services and supplies given by an **out-of-network provider** are covered at the **out-of-network** level of benefits shown in the *Schedule of Benefits*.

Refer to *About the PPO Dental Coverage* for more information about covered services and supplies.]

[Type A Expenses: Diagnostic and Preventive Care]

[VISITS AND X-RAYS
Office visit during regular office hours, for oral examination (limited to [2-6 visits every year] [one visit every 6 months])
Prophylaxis (cleaning) (limited to [2-6 treatments per year] [one treatment every 6 months])
Adult
Child (limited to covered persons under age 14-30)
Topical application of fluoride, (limited to [1-4 courses of treatment per year] [one application every 6 months] [and to covered persons under age 14-30])
Sealants, per tooth (limited to [1-2 application every 1-5 years][one per lifetime] [one application every 6 months] for permanent bicuspids and molars only [and to covered persons under age 14-30])
Bitewing x-rays (limited to 1-4 sets [per year] [every 6 months])
Entire dental series; including bitewings; or panoramic film (limited to 1-8 sets every [1-5 years] [6 months])
Vertical bitewing X-rays (limited to 1-4 sets every [1-5 years] [6 months])]

[Type B Expenses: Basic Restorative Care]

[VISITS AND X-RAYS
Professional visit after hours, (payment will be made on the basis of services rendered or visit, whichever is greater)
Emergency palliative treatment, per visit]

[X-RAY AND PATHOLOGY
Periapical x-rays (single films up to 13-25 films)
Intra-oral, occlusal view, maxillary or mandibular
Upper or lower jaw, extra-oral
Biopsy and histopathologic examination of oral tissue]

[ORAL SURGERY
Extractions
Exposed root or erupted tooth
Surgical removal of erupted tooth
Impacted Teeth
    Removal of tooth (soft tissue)
Odontogenic Cysts and Neoplasms
    Incision and drainage of abscess
    Removal of odontogenic cyst or tumor
Other Surgical Procedures
    Alveoplasty, in conjunction with extractions - per quadrant
    Alveoplasty, not in conjunction with extraction - per quadrant
    Sialolithotomy: removal of salivary calculus
    Closure of salivary fistula
    Excision of hyperplastic tissue
    Removal of exostosis
    Transplantation of tooth or tooth bud
    Closure of oral fistula of maxillary sinus
    Sequestrectomy
    Crown exposure to aid eruption
    Removal of foreign body from soft tissue
    Frenectomy
    Suture of soft tissue injury]

[PERIODONTICS
Occlusal adjustment, (other than with an appliance or by restoration)
Root planing and scaling, per quadrant, (limited to 1-4 separate quadrants every 1-2 years)
Root planing and scaling, 1 to 3 teeth per quadrant, (limited to 1-4 per site every 1-2 years)
Gingivectomy, per quadrant, (limited to 1-2 per quadrant every 1-5 years)
Gingivectomy, 1 to 3 teeth per quadrant, (limited to 1-2 per site every 1-5 years)
Gingival flap procedure, per quadrant, (limited to 1-2 per quadrant every 1-5 years)
Gingival flap procedure, 1 to 3 teeth per quadrant, (limited to 1-2 per site every 1-5 years)
Periodontal maintenance procedures following active therapy, (limited to 1-2 per year)
Localized delivery of chemotherapeutic agents]

[ENDODONTICS
Pulp cap
Pulpotomy
Apexification/recalcification
Apicoectomy
Root canal therapy, including necessary x-rays
    Anterior
    Bicuspid]

[RESTORATIVE DENTISTRY – Excludes inlays, crowns, (other than prefabricated stainless steel or resin), and bridges. Multiple restorations in 1 surface will be considered as a single restoration.
Amalgam restorations
Resin-based composite restorations, [(other than for molars)]
Pins
Pin retention, per tooth, in addition to amalgam or resin restoration
Crowns, (when tooth cannot be restored with a filling material)
Prefabricated stainless steel
Prefabricated resin crown, (excluding temporary crowns)
Recementation
Inlay
Crown
Bridge]

[**NUTRITIONAL COUNSELING and TOBACCO COUNSELING (**limited to nutritional counseling for the control of dental disease and tobacco counseling for the control and prevention of oral disease)**]**

[Type C Expenses: Major Restorative Care]

[ORAL SURGERY
Impacted Teeth
Removal of tooth (partially bony)
Removal of tooth (completely bony)
Brush biopsy]

[PERIODONTICS
Osseous surgery, (including flap and closure), 1 to 3 teeth per quadrant (limited to 1-4 per quadrant every 1-5 years)
Osseous surgery, (including flap and closure), per quadrant (limited to 1-4 per site every 1-5 years
Soft tissue graft procedures
Clinical Crown Lengthening - Hard Tissue
Full mouth debridement (limited to 1-4 per lifetime)
Bone grafts, first site in quadrant (limited to 1-4 per lifetime)
Bone grafts, each additional site in quadrant (limited to 1-4 per lifetime)]

[ENDODONTICS
Root canal therapy, including necessary x-rays
Molar]

[RESTORATIVE – Inlays, onlays, labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge (limited to 1-2 per tooth every 1-10 years.) (See *Replacement Rule.*)
Inlays/Onlays-Metallic or Porcelain/Ceramic
Inlay, 1 or more surfaces
Onlay, 2 or more surfaces

Inlays/Onlays-Resin-based composite
Inlay, 1 or more surfaces
Onlay, 2 or more surfaces
Labial Veneers
Laminate - chairside
Resin laminate – laboratory
Porcelain laminate – laboratory
Crowns
Resin
Resin with noble metal
Resin with base metal
Porcelain
Porcelain with noble metal
Porcelain with base metal
Base metal (full cast)
Noble metal (full cast)
Metallic (3/4 cast)
Post and core
Core Build-Up]

[PROSTHODONTICS – First installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than 1-10 years old. (See *Tooth Missing But Not Replaced Rule*.) Replacement of existing bridges or dentures is limited to 1 every 1-10 years. (See *Replacement Rule*.)
Bridge Abutments (See Inlays and Crowns)
Pontics
Base metal (full cast)
Noble metal (full cast)
Base metal (full cast)
Porcelain with noble metal
Porcelain with base metal
Resin with noble metal
Resin with base metal
Removable Bridge (unilateral)
One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics
Dentures and Partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6-36 months after installation. Fees for relines and rebases include adjustments within 6-36 months after installation. Specialized techniques and characterizations are not eligible.)
Complete upper denture
Complete lower denture
Partial upper or lower, resin base (including any conventional clasps, rests and teeth)
Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
Stress breakers
Interim partial denture (stayplate), anterior only
Office reline
Laboratory reline
Special tissue conditioning, per denture

Rebase, per denture
Adjustment to denture more than [6-36] months after installation
Full and partial denture repairs
Broken dentures, no teeth involved
Repair cast framework
Replacing missing or broken teeth, each tooth
Adding teeth to existing partial denture
Each tooth
Each clasp
Repairs: crowns and bridges
Occlusal guard (for bruxism only)(limited to 1-4 every 1-5 years)]

[IMPLANTS – (limited to 1-10 teeth, [every 1-5 years] [per lifetime])]

[SPACE MAINTAINERS – Only when needed to preserve space resulting from premature loss of decidous teeth. (Includes all adjustments within 6 months after installation**.)**
Fixed (unilateral or bilateral)
Removable (unilateral or bilateral)
Removable inhibiting appliance to correct thumbsucking
Fixed or cemented inhibiting appliance to correct thumb sucking]

[GENERAL ANESTHESIA AND INTRAVENOUS SEDATION – Only when **medically necessary** and provided in conjunction with a covered surgical procedure]

[ORTHODONTICS
Interceptive orthodontic treatment
Limited orthodontic treatment
Comprehensive orthodontic treatment of adolescent dentition
Comprehensive orthodontic treatment of adult dentition
Post treatment stabilization]

[VISITS AND EXAMS
Adjunctive pre-diagnostic tests (limited to 2-6 visits every year)]

[[Comprehensive] [Managed] Dental Expense Insurance Plan]

[In addition to the **covered expenses** listed under [Type A, Type B and Type C] below, the following additional dental expenses will be considered **covered expenses** if you [and your covered dependent] have at least one of the following conditions:

- [Pregnancy;
- Coronary artery disease/cardiovascular disease;
- Cerebrovascular disease; or
- Diabetes]

Additional Covered Dental Expenses (limited to one additional per year)

- [Prophylaxis (cleaning);
- Scaling and root planing, (4 or more teeth); per quadrant;
- Scaling and root planing (limited to 1-3 teeth); per quadrant;
- Full mouth debridement;
- Periodontal maintenance; and
- Localized delivery of antimicrobial agents. (Not covered for pregnancy.)]

Payment of Benefits

[The **plan coinsurance** applied to the additional covered dental expenses above will be 100% for **network** expenses [and 50-100% for out-of-network expenses].] These additional benefits will not be subject to any frequency limits except as shown above.]

[The **copayment** will be waived for the additional covered dental expenses above and will not be subject to any frequency limits except as shown above.]

[**Network**] **Benefits**

This Dental Care Schedule applies to covered services and supplies provided by **Primary Care Dentists** (**PCD**) and other [**network**] **providers** upon referral from your **PCD**. The plan covers only the services and supplies in the list below.

PRIMARY DENTAL SERVICES
[TYPE A EXPENSES]

[VISITS AND EXAMS

- Office visit for oral exam (limited to 2-6 visits per year)
- Emergency palliative treatment
- Prophylaxis (cleaning) (limited to 2-6 treatments per year)
- Topical application of fluoride (limited to 1-4 treatments per year and to covered persons under age 14-30)
- Oral hygiene instruction
- Sealants, per tooth (limited to 1-2 applications every 1-5 years for permanent molars only, and to covered persons under age 14-30)
- Pulp vitality test
- Diagnostic casts]

[X-RAYS AND PATHOLOGY

- Bitewing X-rays (limited to 1-4 set per year)
- Entire dental series, including bitewings, or panoramic film (limited to 1-8 sets every 1-5 years)
- Vertical bitewing X-rays (limited to 1-4 sets every 1-5 years)
- Periapical X-rays
- Intra-oral, occlusal view, maxillary, or mandibular
- Extra-oral upper or lower jaw
- Biopsy and histopathologic examination of oral tissue]

[SPACE MAINTAINERS (Includes all adjustments within 6 months after installation.)

- Fixed, band type
- Removable acrylic with round wire clasp]

[TYPE B EXPENSES]

[ENDODONTICS

- Pulp capping
- Pulpotomy
- Surgical exposure for rubber dam isolation
- Root canal therapy, including necessary X-rays
  - Anterior
  - Bicuspid]

[RESTORATION AND REPAIR

- Amalgam restoration
  - 1 surface
  - 2 surfaces
  - 3 or more surfaces
- Resin restoration [(other than for molars)]
  - 1 surface

  - 2 surfaces
  - 3 or more surfaces or incisal angle
- Retention pins
- Sedative fillings
- Stainless steel crowns
- Prefabricated resin crowns (excluding temporary crowns)
- Recementing inlays, crowns, bridges, space maintainers
- Tissue conditioning for dentures]

[PERIODONTICS
- Scaling and root planing (limited to 1-4 separate quadrants, every 1-2 years)
- Periodontal maintenance procedures following surgical therapy (limited to 1-4 per year)]

[ORAL SURGERY – (Includes local anesthetics and routine post-operative care)
- Extractions, uncomplicated
- Surgical removal of erupted tooth
- Surgical removal of impacted tooth (soft tissue)
- Excision of hyperplastic tissue
- Excision of pericoronal gingiva
- Incision and drainage of abscess
- Surgical exposure of impacted or unerupted tooth to aid eruption
- Root removal, exposed root
- Removal of foreign body from soft tissue
- Suture of soft tissue injury]

[**NUTRITIONAL COUNSELING and TOBACCO COUNSELING** – (limited to nutritional counseling for the control of dental disease and tobacco counseling for the control and prevention of oral disease)**]**

[TYPE C EXPENSES]

[RESTORATIONS

- Inlays
  - 1 surface
  - 2 surfaces
  - 3 or more surfaces
- Onlays
  - 2 surfaces
  - 3 surfaces
  - 4 or more surfaces
- Crowns (including build-ups when necessary)
  - Resin
  - Resin with noble metal
  - Resin with base metal
  - Porcelain
  - Porcelain with noble metal
  - Porcelain with base metal
  - Base metal (full cast)
  - Noble metal (full cast)
  - Metallic (3/4 cast)
  - Post and core
- Pontics
  - Base metal (full cast)
  - Noble metal (full cast)
  - Porcelain with noble metal
  - Porcelain with base metal
  - Resin with noble metal
  - Resin with base metal]

[DENTURES AND PARTIALS – (includes relines, rebases, and adjustments within 6-36 months after installation).

- Full (upper and lower)
- Partial
- Stress breakers (per unit)
- Stayplates
- Crown and bridge repairs
- Adding teeth to an existing denture
- Full and partial denture repairs
- Relining/rebasing dentures (including adjustments within 6-36 months after installation)
- Occlusal guard, (for bruxism only), limited to 1-4 every 1-5 years]

[VISITS AND EXAMS

- Adjunctive pre-diagnostics tests (limited to 2-6 visits per year)]

[PERIODONTICS

- Full mouth debridement (limited to 1-4 per lifetime)
- Local delivery of antimicrobial agents]

[ORAL SURGERY

- Brush biopsy]

[SPECIALTY DENTAL SERVICES
TYPE B EXPENSES]

[ENDODONTICS (Includes local anesthetics where necessary)

- Apexification/recalcification
- Apicoectomy/periradicular surgery, (per tooth), first root
- Apicoectomy, (per tooth), each additional root
- Retrograde Filling
- Root Amputation
- Hemisection
  - Retreatment of previous root canal therapy
    - Anterior
    - Bicuspid
    - Molar
- Molar root canal therapy]

[ORAL SURGERY – (Includes local anesthetics where necessary and post-operative care)

- Surgical removal or root tip, root recovery
- Removal of residual root
- Removal of odontogenic cyst
- Closure of oral fistula
- Removal of foreign body from bone
- Sequestrectomy
- Frenectomy
- Transplantation of tooth or tooth bud
- Alveoplasty in conjunction with extractions, per quadrant
- Alveoplasty not in conjunction with extractions, per quadrant
- Removal of exostosis
- Sialolithotomy, removal of salivary calculus
- Closure of salivary fistula]

[PERIODONTICS

- Gingivectomy or gingivoplasty, per quadrant (limited to 1-4 per quadrant every 1-5 years)
- Gingivectomy or gingivoplasty, per tooth (limited to 1-4 per site every 1-5 years)
- Gingival flap procedure, per quadrant
- Occlusal adjustment (other than with an appliance or by restoration)
- Clinical Crown Lengthening – Hard Tissue]

[TYPE C EXPENSES]

[ENDODONTICS (Includes local anesthetics where necessary)
- Molar root canal therapy, including necessary X-rays]

[INTRAVENOUS SEDATIONS AND GENERAL ANESTHESIA]

[ORAL SURGERY (Includes local anesthetics where necessary and port-operative care)
- Surgical removal of impacted teeth
  - Partially bony
  - Completely bony
  - Completely bony with unusual surgical implications]

[PERIODONTICS
- Osseous surgery, (including flap entry and closure), per quadrant limited to 1-4 per quadrant every 1-5 years
- Soft tissue graft procedure
- Bone grafts, first site in quadrant (limited to 1-4 per lifetime)
- Bone grafts, each additional site in quadrant (limited to 1-4 per lifetime)]

[**IMPLANTS (**limited to 1-10 teeth, [every 1-5 years] [per lifetime])]

[ORTHODONTICS
- Orthodontic screening exam
- Orthodontic diagnostic records
- Orthodontic retention
- Comprehensive orthodontic treatment of adult or adolescent dentition
- Post treatment stabilization
- Removable appliance to correct habits
- Fixed or cemented appliance to correct habits]

Rules and Limits That Apply to the Dental Plan

Several rules apply to the dental plan. Following these rules will help you use the plan to your advantage by avoiding expenses that are not covered by the plan.

[Orthodontic Treatment Rule

Orthodontic treatment is covered [only for covered dependent children who are under age 18 - 21] [on the date active **orthodontic treatment** begins] [on the date the appliance is initially inserted.]

[This benefit does not cover charges for the following:

- Replacement of broken appliances;
- Re-treatment of orthodontic cases;
- Changes in treatment necessitated by an accident;
- Maxillofacial surgery;
- Myofunctional therapy;
- Treatment of cleft palate;
- Treatment of micrognathia;
- Treatment of macroglossia;
- Treatment of primary dentition;
- Treatment of transitional dentition;
- Lingually placed direct bonded appliances and arch wires (i.e. “invisible braces”); or
- Removable acrylic aligners (i.e. “invisible aligners”).]

[The plan will not cover the charges for an orthodontic procedure if an active appliance for that procedure was installed before you were covered by the plan.]]

[Orthodontic Limitation for Late Enrollees

The plan will not cover the charges for an orthodontic procedure for which an active appliance for that procedure has been installed within the [1 - 2] year period starting with the date you became covered by the plan. This limit applies only if you do not become enrolled in the plan within [31 - 90] days after you first become eligible.]

[Waiting Period

The plan has a waiting period for [Type B and Type C Expenses and **orthodontic treatment**]. [With respect to Type B Expenses, your coverage will take effect after [1 - 24] months of continuous coverage under the Plan]. [With respect to Type C Expenses, your coverage will take effect after [1- 24] months of continuous coverage under the plan.] [With respect to **orthodontic treatment**, your coverage will take effect after [1 - 24] months of continuous coverage under the Plan.]

[Replacement Rule

[Crowns, inlays and onlays, veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic items] are subject to this Plan's replacement rule. That means certain replacements of, or additions to, these items are covered only when you give proof to **Aetna** that:

- [While you were covered by this Plan, you had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.]
- The present [crown, inlay and onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic items] was installed at least [6 months - 10 years] before its replacement and cannot be made serviceable.
- [You had a tooth (or teeth) extracted while you were covered by the plan. Your present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within [12 - 36] months from the date that the temporary denture was installed.]]

[Tooth Missing but Not Replaced Rule

The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

- The dentures, bridges or other prosthetic items are needed to replace one or more natural teeth that were removed while you were covered by the plan; and
- [The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior [6 months – 10 years]. [The extraction of a third molar does not qualify.] Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.]]

Exclusions That Apply to [Basic] [Limited] [DMO] [PPO] [Comprehensive] Dental Insurance

Not every dental care service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are included in the [*What the Plan Covers*] section. Charges made for the following are not covered except to the extent listed under the [*What the Plan Covers*] section or by amendment attached to this [*Booklet-Certificate*]. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations. This includes services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.

[These dental exclusions are in addition to the exclusions listed under your medical coverage.]

[Apicoectomy, (dental root resection), root canal treatment.]

[Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery; personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance, augmentation and vestibuloplasty; and other substances to protect, clean, [whiten, bleach] or alter the appearance of teeth, whether or not for psychological or emotional reasons[; except to the extent coverage is specifically provided in the [*What the Plan Covers*] section]. [Facings on molar crowns and pontics will always be considered cosmetic.] [This exclusion does not apply to external bleaching.]]

[Crown, inlays and onlays, and veneers unless:

- It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material; or
- The tooth is an abutment to a covered partial denture or fixed bridge.]

[Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants.]

[Services or supplies furnished by a [**network**] **provider** to the extent that the **negotiated charge** exceeds any maximum allowable amount.]

[Services and supplies provided by an [**out-of-network**] **provider**.]

Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider.

Services and supplies provided in connection with treatment or care that is not covered under the plan.

[Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.]

[Dental services and supplies that are covered in whole or in part:

- Under any other part of this plan; or
- Under any other plan of group benefits provided by the policyholder.]

[Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion[, or correcting attrition, abrasion, or erosion.]]

[First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered.]

[Any instruction for diet, plaque control and oral hygiene.]

[General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply

Except as covered in the [*What the Plan Covers*] section, [non-surgical and surgical] treatment of any **jaw joint disorder** [and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.]

[**Orthodontic treatment** except as covered in the [*What the Plan Covers*] section].

[Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium) except as covered in the [*What the Plan Covers*] section.]

[Prescribed drugs, pre-medication or analgesia.]

[Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.]

[Replacement of teeth beyond the normal complement of 32.]

[Removal of soft bony impactions.]

[Services and supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services.]

[Surgical removal of impacted wisdom teeth when only for orthodontic reasons.]

[Topical application of fluoride.]

[Treatment by other than a **dentist**. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a **dentis**t. These are:

- Scaling of teeth;
- Cleaning of teeth; and
- Topical application of fluoride.]

[Treatment of alveolectomy.]

[Treatment of periodontal disease.]

[Coinsurance

Coinsurance is both the percentage of **covered expenses** that the plan pays, and the percentage of **covered expenses** that you pay.

[As to **covered expenses** incurred from a **network provider**, coinsurance also includes any amount by which the **negotiated charge** exceeds a **maximum allowable amount** under the plan.] [As to **covered expenses** incurred from a [provider] [**out-of-network provider** and for **other health care]**, coinsurance also includes any amount by which the billed charge exceeds a **maximum allowable amount** under the plan.]

The percentage that the plan pays is referred to as "plan **coinsurance**" or the "payment percentage," and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on **coinsurance** amounts.]

[Coinsurance Limit

Your plan has **coinsurance limits**. A **coinsurance limit** is the maximum out-of-pocket amount you are responsible to pay for **coinsurance** for **covered expenses** during your calendar year. Your [**deductibles**, **copayments** and] **coinsurance** and other eligible **covered expenses** apply to the **coinsurance limits**. Once you reach the **coinsurance limits** that apply to your plan, the plan will pay 100 percent of the **covered expenses** that apply toward the limits for the rest of the [calendar year] [and the next calendar year]. [The **coinsurance limits** apply to both [**network**] and [**out-of-network**] benefits.] [You have separate **coinsurance limits** for **network** and **out-of-network** benefits.] There are certain expenses that do not apply toward the **coinsurance limits.** These expenses are listed in the *Coinsurance Provisions* section in the *Schedule of Benefits*.]

[Coma or Comatose

A profound state of unconsciousness from which you [or your covered dependent] cannot be aroused to consciousness, even by powerful stimulation, as certified by a **physician**.]

[Comprehensive Dental Expense Coverage

A plan of dental expense benefits that is an alternative plan to the **Dental Care Plan**.]

[Consumer Price Index

The [unadjusted U.S. City Average] **Consumer Price Index** for Urban Wage Earners and Clerical Workers (CPI-W), is published by the United States Department of Labor. If the CPI-W is discontinued or changed, **Aetna** reserves the right to use a comparable index.]

[Copay, Copayments

The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various **copayments**, and these **copayment** amounts or percentages are specified in the [*Schedule of Benefits*].]

[**Complication of Pregnancy**

This means:

- Any of the following conditions, requiring **hospital** confinement (when the pregnancy is not terminated) whose diagnosis are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy, such as: acute nephritis, pyelitis of pregnancy, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity. **Complication of pregnancy** shall not include false labor, occasional spotting, **physician** prescribed rest during the period of pregnancy, morning sickness and similar conditions associated with the management of a difficult pregnancy not constituting a condition which is medically classified as a distinct **complication of pregnancy**.
- An extra-uterine pregnancy;
- A complication that requires intra-abdominal surgery after termination of pregnancy;
- A miscarriage;
- A non-elective caesarean section;
- An ectopic pregnancy that is terminated;
- A spontaneous termination of pregnancy that occurs when a viable birth is not possible;
- Placenta previa, placenta abruption or premature rupture of membranes;
- Pernicious vomiting of pregnancy (hyperemesis gravidarum); and
- Toxemia (eclampsia or pre-eclampsia).]

[Cosmetic

Services or supplies that alter, improve or enhance appearance.]

[Covered Expenses

Medical, prescription drug, dental, vision or hearing services and supplies shown as covered under this Booklet-Certificate.]

[CPT Code

This means the code assigned to a service that is listed in the **Physician**'s Current Procedural Terminology Manual.]

[Creditable Coverage

A person's prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Such coverage includes:

- Health coverage issued on a group or individual basis;
- Medicare;
- Medicaid;
- Health care for members of the uniformed services;
- A program of the Indian Health Service;
- A state health benefits risk pool;
- The Federal Employees' Health Benefit Plan (FEHBP);
- A public health plan (any plan established by a State, the government of the United States, or any subdivision of a State or of the government of the United States, or a foreign country);
- Any health benefit plan under Section 5(e) of the Peace Corps Act; and
- The State Children's Health Insurance Program (S-Chip).]

[Custodial Care

Services and supplies that are primarily intended to help you meet personal needs. **Custodial Care** can be prescribed by a **physician** or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of **custodial care** include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering oral medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care;
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.]

SERFF Tracking #:	*AENX-G128750752*	***State Tracking #:***	***Company Tracking #:*** *AR062980100004*

State:	*Arkansas*	***Filing Company:***	*Aetna Life Insurance Company*
TOI/Sub-TOI:	*H10G Group Health - Dental/H10G.000 Health - Dental*		
Product Name:	*2012 DEN- Dental Enhancements (ALIC)*		
Project Name/Number:	*2012 DEN- Dental Enhancements (ALIC)/AR062980100004*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Bypassed - Item:	Application	Approved	11/08/2012
Bypass Reason:	not applicable		

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification	Approved	11/08/2012
Comments:	Schedule page forms are excepted from Flesch score requirements. The forms will equal or exceed the minimum reading ease score when incorporated into the group policy.		

		Item Status:	**Status Date:**
Satisfied - Item:	Cover Letter, Attachment A, GR-9N S-09-05 04, GR-9N S-09-20 04, GR-9N S-09-41 01, GR-9N S-20-005 05, GR-9N S-20-020 02, GR-9N S-21-005 05, GR-9N S-21-010 05, GR-9N S-21-020 02, GR-9N S-21-025 01, GR-9N S-22-010 06, GR-9N S-22-020 04, GR-9N S-23-005 , ...	Approved	11/08/2012
Comments:			
Attachment(s):			

SERFF Tracking #:	AENX-G128750752	**State Tracking #:**		**Company Tracking #:**	AR062980100004

State:	Arkansas	**Filing Company:**	Aetna Life Insurance Company
TOI/Sub-TOI:	H10G Group Health - Dental/H10G.000 Health - Dental		
Product Name:	2012 DEN- Dental Enhancements (ALIC)		
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ALIC 2012 Dental Enhancements CovLtr.PDF
2012 Dental Enhancements Attachment A ALIC.PDF
AL GE EGR9N0S0905 V004.PDF
AL GE EGR9N0S0920 V004.PDF
AL GE EGR9N0S0941 V001.PDF
AL GE EGR9NS20005 V005.PDF
AL GE EGR9NS20020 V002 .PDF
AL GE EGR9NS21005 V005.PDF
AL GE EGR9NS21010 V005.PDF
AL GE EGR9NS21020 V002.PDF
AL GE EGR9NS21025 V001.PDF
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AL GE EGR9N028025 V004.PDF
AL GE EGR9N034015 V007.PDF

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October 31, 2012

Insurance Commissioner Jay Bradford
Compliance - Life and Health
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

Subject: **Aetna Life Insurance Company, NAIC No. 001-60054**
Group Accident and Health Insurance
Form: GR-9N S-09-005 04, et al

Dear Commissioner:

The booklet-certificate forms listed on the Attachment A to this filing are being submitted, for your Department's approval on a general use basis. The forms are new and do not replace any previously filed forms. They are in final form rather than being a draft or proof.

The purpose of this filing is to support the following options for our dental products:

PPO and Fee for Service Dental Products

- Calendar Year Benefit Maximum Flexibility
    1. 1) Specify the service categories (preventive, basic or major) to which the calendar year maximum applies.
    2. 2) Allow for separate calendar year maximums by service category (preventive, basic or major).
    3. 3) Revised the calendar year maximum to consistently show a range of $250 – 10,000 in all plans where inclusion of this maximum is a plan option.
- Coverage for counseling on the topics of smoking cessation and nutrition.
- Added language that allows an additional cleaning covered at 100% under plans where the member is also covered under an Aetna medical plan and has a specific medical condition or conditions. These medical conditions include pregnancy, coronary artery disease/cardiovascular disease or diabetes.
- Revised the orthodontic lifetime maximum to consistently show a benefit range of $250-5,000 in all plans where inclusion of this maximum is a plan option.
- Deductibles:
    1) Specify the service categories (preventive, basic or major) to which the calendar year deductible applies.

2) Allow for separate calendar year deductibles by service category (preventive, basic or major).

- Revised the coinsurance range for Type A (preventive) services to lower the minimum percentage the plan pays in that range from 70% to 50%.
- Frequency Limits:
  1) Expanded the frequency options for sealants to cover them once per lifetime or once every six months.
  2) Reline or rebase of denture once every 6-36 months.
  3) Expanded the frequency limits for gingivectomy, osseous surgery and gingival flap procedure.
  4) Expanded the frequency options for exams and x-rays to cover them once every 6 months.
- Under the dental exclusions and limitations section, added variability to support the removal of certain exclusions when those services are covered under the plan.

DMO Dental Products –

- Included an option to cover implants.
- Coverage for counseling on the topics of smoking cessation and nutrition.
- Added language that allows an additional cleaning covered at 100% under plans where the member is also covered under an Aetna medical plan and has a specific medical condition or conditions. These medical conditions include pregnancy, coronary artery disease/cardiovascular disease or diabetes.
- Under the dental exclusions and limitations section, added variability to support the removal of certain exclusions when those services are covered under the plan.
- Added a teeth whitening (external bleaching) benefit.
- The ability to support a fixed copayment for orthodontic services under a coinsurance plan.

The enclosed form is intended to be used with the GR-29N policy and GR-9N booklet-certificate forms that were approved on the dates listed below.

- Booklet-Certificate Form GR-9N was approved by your Department on June 23, 2006; and
- Wraparound Style Policy Form GR-29N was approved by your Department on June 23, 2006.

Variability

Variability, as indicated by bracketed material on the form, is required so that only the appropriate language may be reflected on the form. Upon issuance of this document, the placement of textual material may vary to avoid gaps that would otherwise be created by the deletion of bracketed material. Provisions may appear in sequence other than that shown. Connective words and phrases, which serve the grammatical purpose of meaningful continuity and do not affect the description of the payment of benefits or other terms or conditions of the group policy, may vary as the sense demands. Detailed Explanations of Variability for the forms have been included.

We trust that you will find everything in order, and we look forward to your approval of the enclosed forms. If you have any questions regarding this submission, please do not hesitate to contact me at the above mailing address, telephone number or e-mail address.

Sincerely,

John W Ciesielski
Senior Consultant

Enclosures

Attachment A

GR-9N Schedule of Benefits Forms:

Expense Insurance Provisions

- GR-9N S-09-05 04
- GR-9N S-09-20 04
- GR-9N S-09-41 01

Indemnity/Comprehensive Dental

- GR-9N S-20-005 05
- GR-9N S-20-020 02

PPO Dental

- GR-9N S-21-005 05
- GR-9N S-21-010 05
- GR-9N S-21-020 02
- GR-9N S-21-025 01

DMO Fixed Copay

- GR-9N S-22-010 06
- GR-9N S-22-020 04
- GR-9N S-30-010 07

DMO Coinsurance

- GR-9N S-23-005 02
- GR-9N S-23-010 03

GR-9N Booklet-Certificate Forms:

Dental Coverage

- GR-9N 16-025 03

PPO and Indemnity/Comprehensive Dental

- GR-9N 18-006 02
- GR-9N 18-010 05

DMO Dental

- GR-9N 19-006 02
- GR-9N 19-010 04

Dental Rules and Limits

- GR-9N 20-005 03
- GR-9N 20-010 02

Exclusions

- GR-9N 28-025 04

Glossary

- GR-9N 34-015 07

Aetna Life Insurance Company
Explanation of Variability
Schedule of Benefits
GR-9N
S-09-05
04

Items identified as "Drafting Notes" throughout the Form: These notes will not print when the forms are provided to Policyholders. They are used as a clarifying note to examiners and for Aetna's use to assist in the electronic assembly of a Policyholder's specific documents.

General Comments

- Variability, as indicated by brackets surrounding variable text, is required so that only the appropriate information will be reflected based upon the plan of benefits or provisions selected by the Policyholder.
- The reference to "Schedule of Benefits" may be changed, for example, to "Summary of Benefits", "Schedule of Coverage" or "Summary of Coverage".
- The references to "employee" may be changed to "subscriber", "enrollee", "member" or other term as applicable to the classification of covered persons under the policyholder's plan.
- The references to "calendar year" may be changed to "policy year", "coverage year", "plan year" or other interval.
- The phrase "and the following year" may be added as a liberalization to the end of the following sentence wherever it appears on this form:
  "After covered expenses reach this family [calendar year] deductible, this Plan will begin to pay benefits for covered expenses that you and your covered dependents incur from a [will show any and all applicable providers] for the rest of the [calendar year.].
- The reference to "policyholder" may be changed to "employer", "association", "plan sponsor", "contract holder", "participating employer", "member group" or other term of similar meaning.
- The fields in the upper right "header" are variable and illustrative. When included upon issue, they will be completed to reflect the name of the policyholder, the group policy number and the coverage effective date.
- The term "Booklet-Certificate" may be changed to "Certificate", "Certificate of Insurance" or some other name of similar meaning as used in a policyholder's forms.
- The references to "network" may be changed to "in-network", "participating", "preferred" or some other term of similar meaning.
- The references to "out-of-network' may be changed to "non-participating", non-preferred", "non-network' or some other term of similar meaning.
- The references and provisions that apply to "dependents" will print if such coverage is provided for or applicable under a Policyholder's plan of benefits.
- The applicable page number at the bottom of the form will print upon issue.
- The bracketed designations [00000] at the bottom right corner is a field reserved for Aetna's use to allow for the addition of a drafting system code that assists with the electronic assembly of Policyholder specific documents. Upon issue of this form, the bracketed term [State] will be omitted if the page has not been modified due to state requirements. If the page has been modified, then the postal abbreviation of your state may be added to identify that the form is state specific.

Aetna Life Insurance Company
Explanation of Variability
Schedule of Benefits
GR-9N
S-09-05
04

GR-9N, S-09-05 04

- *First and Second Paragraphs:* The applicable insurance coverage type for the policyholder's plan will be listed. All other coverage types will be omitted.
- *Deductible Provisions:*
  - This section contains various deductible options that may be incorporated into a policyholder's plan design. Options not applicable to a policyholder's plan will be omitted upon issue. The entire section may be omitted if deductibles are not part of the policyholder's plan.
  - First Paragraph: The references to "network, out of network, and other health care" deductibles may be included for network style plan designs. The deductible amounts may differ between benefit levels for network style plan designs. The word "not" will print when the plan does not permit cross application of the deductibles.
  - Second Paragraph: The second paragraph will be included, and will be modified as appropriate, when the calendar year deductible is integrated for any combination of, or all products listed. If separate deductibles apply, it will be noted on the appropriate section of the Schedule of Benefits.
  - Third Paragraph: This paragraph will print when there are deductible provisions in the plan. The language that discusses "maximum allowable amounts" that begins with "and the following" will print when the policyholder's plan includes this provision.
    a. The first bulleted item will print for plans that include a network component and the maximum allowable amount applies to network providers.
    b. The second bulleted item will print for Major and Comprehensive Medical plans. It will also print for plans that include a network component and the maximum allowable amounts apply to out-of-network provider and/or for other health care.
  - Fourth Paragraph: The plan may contain an individual deductible only. If so, [and family] will be omitted.
- *Calendar Year Deductibles - Option 1 and Option 2*
  - A policyholder's plan may include individual and family deductible combinations as follows:
    a. A combined deductible for all benefit levels; or
    b. Combined deductibles, in any combination, for network providers, out-of-network benefits, and other health; or
    c. Separate deductibles for network providers, out-of-network benefits, and for other health care; or
    d. A network provider and/or out-of-network deductible only.
  - The plan may contain an individual deductible only, or both an individual and a family deductible.
  - Only as to the deductibles identified as Option 1, if a family deductible is included, it will be either the family deductible or the family deductible limit, but not both.
  - The two indented paragraphs under the "Family Deductible Limit" are options. Only one of the options will appear for any given policyholder.

- The "added benefit" paragraph under the “Family Deductible Limit” is optional and may be included at the election of the policyholder. It may be used as an alternative to the waiver of the calendar year deductible. If included, the percentage may vary within the range shown. The last sentence which reads "This added benefit does not count toward any lifetime maximum benefit for you or your dependents" will only be available for plans that are not subject to PPACA requirements.

- *Common Accident Deductible Limit:* If included, this provision may apply separately, in various combinations or combined overall for network provider expenses, out of network expenses, and other health care expenses. The last sentence which reads "This added benefit does not count toward any lifetime maximum benefit for you or your dependents" will only be available for plans that are not subject to PPACA requirements.
- *Deductible Carryover*: This optional provision may be included at the election of the policyholder. If included, the number of months at the end of the year will vary within the range shown.
- *Separate Accident Benefit*: This optional provision may be included at the election of the policyholder.

Aetna Life Insurance Company
Explanation of Variability
Schedule of Benefits
GR-9N
S-09-20
04

Items identified as "Drafting Notes" throughout the Form: These notes will not print when the forms are provided to Policyholders. They are used as a clarifying note to examiners and for Aetna's use to assist in the electronic assembly of a Policyholder's specific documents.

General Comments:

- Variability, as indicated by brackets surrounding variable text, is required so that only the appropriate information will be reflected based upon the plan of benefits or provisions selected by the Policyholder.
- The references to "Coinsurance Limit" may be changed to the "Payment Limit". In addition, the term may be changed to "Out-of-Pocket Limit" for those plans where any applicable copayments and deductibles accumulate toward the limit.
- The references to "Schedule of Benefits" may be changed, for example, to "Summary of Benefits", "Schedule of Coverage" or "Summary of Coverage".
- The references to "employee" may be changed to "subscriber", "enrollee", "member" or other term as applicable to the classification of covered persons under the policyholder's plan.
- The references to "calendar year" may be changed to "policy year", "coverage year", "plan year" or other interval.
- The phrase "and the following year" may be added as a liberalization to the end of the following sentence wherever it appears on this form:

  "Once the amount of eligible expenses you [and your covered dependent] have paid during the [calendar year] meets the individual [coinsurance] limit, this Plan will pay 100% of the covered expenses that apply toward the limit for the rest of the [calendar year]."
- The reference to "policyholder" may be changed to "employer", "association", "plan sponsor", "contract holder", "participating employer", "member group" or other term of similar meaning.
- The fields in the upper right "header" are variable and illustrative. Upon issue they will be completed to reflect the name of the policyholder, the group policy number and the coverage effective date.
- The references to "network" may be changed to "in-network", "participating", "preferred" or some other term of similar meaning.
- The references to "out-of-network' may be changed to "non-participating", non-preferred", "non-network' or some other term of similar meaning.
- The references and provisions that apply to "dependents" will print if such coverage is provided for or applicable under a Policyholder's plan of benefits.
- The applicable page number at the bottom of the form will print upon issue.
- The bracketed designations [00000] at the bottom right corner is a field reserved for Aetna's use to allow for the addition of a drafting system code that assists with the electronic assembly of Policyholder specific documents. Upon issue of this form, the bracketed term [State] will be omitted if the page has not been modified due to state requirements. If the page has been modified, then the postal abbreviation of your state may be added to identify that the form is state specific.

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- *Coinsurance Provisions*: This provision will print for any plan containing coinsurance.
- *Coinsurance*: The second paragraph will print when the plan includes a maximum allowable amount provision. The first sentence will print for plans that include a network component and the maximum allowable amount applies to network providers. The second sentence will print for Major and Comprehensive Medical plans. It will also print for plans that include a network component and the maximum allowable amounts apply to out-of-network providers and/or for other health care.
- *Coinsurance Limit – Option 1 and Option 2:*
  - This section will be included when the plan contains a coinsurance limit.
  - Network, out of network, and other health care coinsurance limits may be included in network style plan designs. A policyholder's plan may include individual and family coinsurance limit combinations as follows:
    a. A combined coinsurance limit for all benefit levels; or
    b. Combined coinsurance limits, in any combination, for network providers; out-of-network benefits; and other health; or
    c. Separate coinsurance limits for network providers; out-of-network benefits, and for other health care; or
    d. A network provider and/or out-of-network coinsurance limit only.

    The coinsurance limit amounts may differ between benefit levels.
  - Option 1 only, if a family coinsurance limit is included, it will be either the family coinsurance or the family coinsurance limit, but not both.
- *Expenses That Do Not Apply To Your Coinsurance Limit*:
  - This section will be included when a plan has a coinsurance limit. It will contain a list of expenses that do not accumulate towards the coinsurance limit. The list may vary from plan to plan.
  - Second Bullet: The term "charge" may be changed to "amount" or another term of similar meaning.
  - Third and Fourth Bullets: These bullets will print when the policyholder's plan includes a "maximum allowable amounts" provision.
    a. Third Bullet: This will print for plans that include a network component and the maximum allowable amount applies to network providers.
    b. Fourth Bullet: This will print for Major and Comprehensive Medical plans. It will also print for plans that include a network component and the maximum allowable amounts apply to out-of-network providers and for other health care.
  - Seventh Bullet: The phrase "outpatient prescription drugs" will print if applicable to the policyholder's plan. When included in the plan, the term "mental disorder" may be changed to "mental illness" or "severe mental illness". In addition, the term "chemical dependency" may be changed to "substance abuse", "alcohol and drug abuse" or "alcoholism".
  - Twelfth Bullet: This bullet will be omitted if the policyholder's plan does not include the precertification features. The words, "precertification" or "precertified", may be changed to "pre-authorization" or another term of similar meaning as used within a policyholder's forms.
  - This list may be expanded to include additional items in accordance with those items identified later in the Schedule of Benefits under the cost-sharing section.

Aetna Life Insurance Company
Explanation of Variability
Schedule of Benefits
GR-9N
S-09-41
01

General Comments

- Variability, as indicated by brackets surrounding variable text, is required so that only the appropriate information will be reflected based upon the plan of benefits or provisions selected by the customer.
- The reference to “policyholder” may be changed to "employer", "association", "plan sponsor", "contract holder", "participating employer", "member group" or other term of similar meaning.
- The fields in the upper right “header” are variable and illustrative. When included upon issue, they will be completed to reflect the name of the policyholder, the group policy number and the coverage effective date.
- The references to "Schedule of Benefits" may be changed to "Summary of Benefits" or some other name of similar meaning as used in a policyholder's forms.
- The term “network” may be changed to “preferred”, “participating” or a term of similar meaning. The term “out-of-network” may be changed to “non-preferred”, “non-participating” or a term of similar meaning.
- The applicable page number at the bottom of the form will print upon issue.
- The bracketed designations [00000] at the bottom right corner is a field reserved for Aetna's use to allow for the addition of a drafting system code that assists with the electronic assembly of Policyholder specific documents. Upon issue of this form, the bracketed term [State] will be omitted if the page has not been modified due to state mandates. If the page has been modified, then the postal abbreviation of your state may be added to identify that the form is state specific.

Aetna Life Insurance Company
Explanation of Variability
Schedule of Benefits
GR-9N
S-20-005
05

This form will be used with a fee for service dental plan.

General Comments

- Any references to "calendar year" may be changed to “year”, "plan year", “policy year”, “365 consecutive day period”, or “12 consecutive month periods”.
- Variability, as indicated by brackets surrounding variable text, is required so that only the appropriate information will be reflected based upon the plan of benefits or provisions selected by the customer.
- The reference to “policyholder” may be changed to "employer", "association", "plan sponsor", "contract holder", "participating employer", "member group" or other term of similar meaning.
- The fields in the upper right “header” are variable and illustrative. When included upon issue, they will be completed to reflect the name of the policyholder, the group policy number and the coverage effective date.
- Throughout the form are bracketed dollar amounts which are stated in ranges. These ranges reflect Aetna's standard offerings. However, in some instances, different amounts may print in a form issued to a policyholder but only if the amounts are more liberal to the policyholder or the covered person. Please be assured that these more liberal amounts will not result in a departure from the intent and purpose of the provision and will be in full compliance with any applicable state laws and regulations.

1. Calendar Year Deductible – This item will be included when the plan has a calendar year deductible and may be omitted if a calendar year deductible is not applicable to the policyholder’s plan.

The calendar year deductible amount may apply as an overall deductible or this provision will specify the expenses to which the calendar year deductible applies.

2. Lifetime Individual Deductible – This item will be included when the plan has a lifetime individual deductible and may be omitted if a lifetime individual deductible is not applicable to the policyholder’s plan.

The lifetime individual deductible amount may apply as an overall deductible or this provision will specify the expenses to which the lifetime individual deductible applies.

3. This paragraph will be included when the dental plan deductibles are integrated with deductibles for other coverages under the plan. This item will specify which coverages are included as part of the integrated deductible.

4. Orthodontic Deductible - This item will be included when the plan has an orthodontic deductible and may be omitted if an orthodontic deductible is not applicable to the policyholder’s plan.

The deductible may apply on a calendar year, plan year or lifetime basis. When the deductible applies on a lifetime basis, the end of the second sentence will refer to the covered person's lifetime rather than the remainder of the calendar year

5. **Plan Coinsurance -** The Plan Coinsurance will be included when the plan uses coinsurance for all covered expense categories. The policyholder will have the option of electing the following coinsurance percentage levels:
   - Type A Expenses will range from 100% to 50%;
   - Type B Expenses will range from 100% to 30%;
   - Type C Expenses will range from 100% to 30%; and
   - Orthodontic Treatment will range from 100% to 30%.

   The references to Type A, B, and C expenses will be deleted if services are consolidated into one list. The reference to Type C expenses will be deleted if these services are combined with the Type B expense list.

   In response to policyholder needs, a dental plan may cover only Type A dental expenses, Type A and Type B dental expenses, Type A and Type B and Type C dental expenses, or only Type C dental expenses.

6. **Plan Coinsurance Limit** – The plan may have an individual limit or both an individual and a family limit.

7. A policyholder may elect to exclude certain covered expenses from application toward the Coinsurance Limit. When elected, the policyholder may include all or any of the covered expenses listed. In the second bullet, the term "recognized charge" may be changed to "negotiated charge", "reasonable charge", "usual and customary charge", or words of similar meaning. In addition, the word "charge" may be changed to amount.

8. **Calendar Year Maximum Benefit** – This item will be included when the plan has a calendar year maximum benefit and may be omitted if a calendar year maximum benefit is not applicable to the policyholder's plan.

   The calendar year maximum benefit amount may apply as an overall calendar year maximum or this provision will specify the expenses to which the calendar year maximum benefit applies.

   The second paragraph will be included when the dental plan maximums are integrated with maximums for other coverages under the plan. This item will specify which coverages are included as part of the integrated maximum.

9. **Lifetime Maximum Benefit** –The second paragraph will be included when the dental plan maximums are integrated with maximums for other coverages under the plan. This item will specify which coverages are included as part of the integrated maximum.

Aetna Life Insurance Company
Explanation of Variability
Schedule of Benefits
GR-9N
S-20-020
02

This Dental Care Schedule will be used with a fee for service dental plan.

General Comments

The fields in the upper right "header" are variable and illustrative. Upon issue they will be completed to reflect the name of the policyholder, the group policy number and the coverage effective date. This item may be omitted, appear only on the first page of each Schedule of Benefits or appear only on the cover page.

The services listed in the Dental Care Schedule are variable. Dental services or supplies may be included or omitted in accordance with the policyholder's plan of benefits and with Aetna's standard plan offerings. Dental services and supplies may be deleted or modified, or new dental services and supplies may be added as a result of changes in standard dental practice, technology and terminology, and as a result of coding changes recommended or adopted by the American Dental Association. Please be assured that any member copay for a new service or supply will not exceed 30% of the covered expense, and the plan coinsurance for a new service or supply will not be less than 30% of the covered expense. In addition, this variability will not be used to add new services and supplies if benefit limitations are also included. Should any benefit limitations apply Aetna will file forms to support the change(s).

Any references to "year" may be changed to "calendar year", "plan year", "policy year", "365 consecutive day period", or "12 consecutive month periods". Any references to "6 months" may be changed to "6 consecutive month periods".

The list of covered services may be revised to move services from one category to another, or to consolidate services into one list.

All endodontic, periodontic and/or oral surgery services may be moved to the major restorative category Type C Services.

In response to policyholder needs, a dental plan may cover only Type A and Type B dental expenses, Type A and Type B and Type C dental expenses, or only Type C dental expenses.

The references to Type A, B, and C expenses will be deleted if services are consolidated into one list. The reference to Type C expenses will be deleted if these services are combined with the Type B expense list.

The section on orthodontics may be omitted if the policyholder's plan of benefits does not include coverage for orthodontia expenses. When Comprehensive orthodontic treatment is covered, the treatment may be limited to adolescent only or adult dentition only.

Aetna Life Insurance Company
Explanation of Variability
Schedule of Benefits
GR-9N
S-20-020
02

Type A Expenses, Type B Expenses and Type C Expenses

Throughout the forms, there are bracketed amounts such as visit limits, ages, number of treatments, applications, sites, quadrants, and guards, or amounts which are stated in ranges. These ranges reflect Aetna's standard offerings. However, in some instances, different amounts may print in a form issued to a policyholder but only if the amounts are more liberal to the policyholder or the covered person. Please be assured that these more liberal amounts will not result in a departure from the intent and purpose of the provision and will be in full compliance with any applicable state laws and regulations.

Any expenses limited to children only (fluoride and sealants), may be expanded to adults. If expenses are expanded to adults, the references to covered persons will be removed.

Nutritional Counseling and Tobacco Counseling

When included, the contract holder may elect to cover only Nutritional Counseling or only Tobacco Counseling or may elect to cover both.

Aetna Life Insurance Company
Explanation of Variability
PPO – Comprehensive Dental Expense Insurance
Schedule of Benefits
GR-9N
S-21-005
05

This form will be used with a fee for service dental plan with the option of using a network of preferred providers.

General Comments

The services listed in the Dental Care Schedule are variable. Dental services or supplies may be included or omitted in accordance with the policyholder's plan of benefits and with Aetna's standard plan offerings. Dental services and supplies may be deleted or modified, or new dental services and supplies may be added as a result of changes in standard dental practice, technology and terminology, and as a result of coding changes recommended or adopted by the American Dental Association. Please be assured that any member copay for a new service or supply will not exceed 30% of the covered expense, and the plan coinsurance for a new service or supply will not be less than 30% of the covered expense. In addition, this variability will not be used to add new services and supplies if benefit limitations are also included. Should any benefit limitations apply Aetna will file forms to support the change(s).

- Any references to "calendar year" may be changed to "year", "plan year", "policy year", "365 consecutive day period", or "12 consecutive month periods".
- The "Network" heading may be changed to "in-network", "participating", "preferred" or some other term of similar meaning. The "Out-of-Network" heading may be changed to "non-participating", non-preferred", "non-network' or another term of similar meaning.
- Variability, as indicated by brackets surrounding variable text, is required so that only the appropriate information will be reflected based upon the plan of benefits or provisions selected by the customer.
- The reference to "policyholder" may be changed to "employer", "association", "plan sponsor", "contract holder", "participating employer", "member group" or other term of similar meaning.
- The fields in the upper right "header" are variable and illustrative. When included upon issue, they will be completed to reflect the name of the policyholder, the group policy number and the coverage effective date.
- Throughout the form are bracketed dollar amounts which are stated in ranges. These ranges reflect Aetna's standard offerings. However, in some instances, different amounts may print in a form issued to a policyholder but only if the amounts are more liberal to the policyholder or the covered person. Please be assured that these more liberal amounts will not result in a departure from the intent and purpose of the provision and will be in full compliance with any applicable state laws and regulations.

1. Calendar Year Deductible

This item will be included when the plan has a calendar year deductible and may be omitted if a calendar year deductible is not applicable to the policyholder's plan.

The calendar year deductible amount may apply as an overall deductible or this provision will specify the expenses to which the calendar year deductible applies. This deductible may be shown as:

a. A combined network and out-of-network deductible; or
b. A separate deductible for network and out-of-network benefits; or
c. An out-of-network deductible only.

If b. above is included, the network deductible will never be greater than the out-of-network deductible.

2. Lifetime Individual Deductible

This item will be included when the plan has a lifetime individual deductible and may be omitted if a lifetime individual deductible is not applicable to the policyholder's plan.

The lifetime individual deductible amount may apply as an overall deductible or this provision will specify the expenses to which the lifetime individual deductible applies. This deductible may be shown as:

a. A combined network and out-of-network deductible; or
b. A separate deductible for network and out-of-network benefits; or
c. An out-of-network deductible only.

If b. above is included, the network deductible will never be greater than the out-of-network deductible.

3. This paragraph will be included when the dental plan deductibles are integrated with deductibles for other coverages under the plan. This item will specify which coverages are included as part of the integrated deductible.

4. Orthodontic Deductible

This item will be included when the plan has an orthodontic deductible and may be omitted if an orthodontic deductible is not applicable to the policyholder's plan.

The orthodontic deductible amount may apply as an overall deductible. This deductible may be shown as:

d. A combined network and out-of-network deductible; or
e. A separate deductible for network and out-of-network benefits; or
f. An out-of-network deductible only.

If b. above is included, the network deductible will never be greater than the out-of-network deductible.

When included, the deductible may apply on a calendar year, plan year or lifetime basis. When the deductible applies on a lifetime basis, the end of the second sentence will refer to the covered person's lifetime rather than the remainder of the calendar year.

Aetna Life Insurance Company
Explanation of Variability
Schedule of Benefits
GR-9N
S-21-010
05

This form will be used with a fee for service dental plan with the option of using a network of preferred providers.

General Comments

- Any references to “calendar year” may be changed to “year”, “plan year”, “policy year”, “365 consecutive day period”, or “12 consecutive month periods”.
- The “Network” heading may be changed to “in-network”, “participating”, “preferred” or some other term of similar meaning. The “Out-of-Network” heading may be changed to “non-participating”, non-preferred”, “non-network’ or another term of similar meaning.
- The term "maximum allowable amount" may be changed to "scheduled limit".
- Variability, as indicated by brackets surrounding variable text, is required so that only the appropriate information will be reflected based upon the plan of benefits or provisions selected by the customer.
- The reference to “policyholder” may be changed to "employer", "association", "plan sponsor", "contract holder", "participating employer", "member group" or other term of similar meaning.
- The fields in the upper right “header” are variable and illustrative. When included upon issue, they will be completed to reflect the name of the policyholder, the group policy number and the coverage effective date.
- Throughout the form are bracketed dollar amounts which are stated in ranges. These ranges reflect Aetna's standard offerings. However, in some instances, different amounts may print in a form issued to a policyholder but only if the amounts are more liberal to the policyholder or the covered person. Please be assured that these more liberal amounts will not result in a departure from the intent and purpose of the provision and will be in full compliance with any applicable state laws and regulations.

-

1. **Coinsurance -** The Plan Coinsurance will be included when the plan uses coinsurance for all covered expense categories. The policyholder will have the option of electing the following coinsurance percentage levels:

   Type A Expenses will range from 100% to 50% and may include the text "up to the maximum allowable amount shown on the Dental Care Schedule";
   Type B Expenses will range from 100% to 30% and may include the text "up to the maximum allowable amount shown on the Dental Care Schedule ";
   Type C Expenses will range from 100% to 30% and may include the text "up to the maximum allowable amount shown on the Dental Care Schedule "; and
   Orthodontic Treatment will range from 100% to 30% and may include the text "up to the maximum allowable amount shown on the Dental Care Schedule ".

   The references to Type A, B, and C expenses will be deleted if services are consolidated into one list. The reference to Type C expenses will be deleted if these services are combined with the Type B expense list.

In response to policyholder needs, a dental plan may cover only Type A dental expenses, Type A and Type B dental expenses, Type A and Type B and Type C dental expenses, or only Type C dental expenses.

2. **Plan Coinsurance Limit**- When included under the policyholder's plan, the plan may have an individual limit or both an individual and a family limit.

   In the paragraph that begins, "Certain covered expenses…" the covered expenses which are not applied to the limit will be listed or the item may be omitted. In the second bullet, the term "recognized charge" may be changed to "negotiated" charge.

   3. **Calendar Year Maximum Benefit**- This item will be included when the plan has a calendar year maximum benefit and may be omitted if a calendar year maximum benefit is not applicable to the policyholder's plan.

   The calendar year maximum benefit amount may apply as an overall maximum benefit amount or this provision will specify the expenses to which the calendar year maximum benefit applies. This maximum may be shown as:

   a. A combined network and out-of-network maximum; or
   b. A separate maximum for network and out-of-network benefits; or
   c. An out-of-network maximum only.

   If b. above is included, the network maximum will never be greater than the out-of-network maximum.

   The fourth paragraph will be included when the dental plan maximums are integrated with maximums for other coverages under the plan. This item will specify which coverages are included as part of the integrated maximum.

4. **Lifetime Maximum Benefit**- The fourth paragraph will be included when the dental plan maximums are integrated with maximums for other coverages under the plan. This item will specify which coverages are included as part of the integrated maximum.

Aetna Life Insurance Company
Explanation of Variability
Schedule of Benefits
GR-9N
S-21-020
02

This Dental Care Schedule will be used with a PPO dental plan.

General Comments

The fields in the upper right "header" are variable and illustrative. Upon issue they will be completed to reflect the name of the policyholder, the group policy number and the coverage effective date. This item may be omitted, appear only on the first page of each Schedule of Benefits or appear only on the cover page.

The services listed in the Dental Care Schedule are variable. Dental services or supplies may be included or omitted in accordance with the policyholder's plan of benefits and with Aetna's standard plan offerings. Dental services and supplies may be deleted or modified, or new dental services and supplies may be added as a result of changes in standard dental practice, technology and terminology, and as a result of coding changes recommended or adopted by the American Dental Association. Please be assured that any member copay for a new service or supply will not exceed 30% of the covered expense, and the plan coinsurance for a new service or supply will not be less than 30% of the covered expense. In addition, this variability will not be used to add new services and supplies if benefit limitations are also included. Should any benefit limitations apply Aetna will file forms to support the change(s).

Any references to "year" may be changed to "calendar year", "plan year", "policy year", "365 consecutive day period", or "12 consecutive month periods". Any references to "6 months" may be changed to "6 consecutive month periods".

All endodontic, periodontic and/or oral surgery services may be moved to the major restorative category Type C Services.

In response to policyholder needs, a dental plan may cover only Type A and Type B dental expenses, Type A and Type B and Type C dental expenses, or only Type C dental expenses.

The references to Type A, B, and C expenses will be deleted if services are consolidated into one list. The reference to Type C expenses will be deleted if these services are combined with the Type B expense list.

Type A Expenses, Type B Expenses and Type C Expenses

Throughout the forms, there are bracketed amounts such as visit limits, ages, number of treatments, applications, sites, quadrants, and guards, or amounts which are stated in ranges. These ranges reflect Aetna's standard offerings. However, in some instances, different amounts may print in a form issued to a policyholder but only if the amounts are more liberal to the policyholder or the covered person. Please be assured that these more liberal amounts will not result in a departure from the intent and purpose of the provision and will be in full compliance with any applicable state laws and regulations.

Any expenses limited to children only (fluoride and sealants), may be expanded to adults. If expenses are expanded to adults, the references to covered persons will be removed.

Nutritional Counseling and Tobacco Counseling

When included, the contract holder may elect to cover only Nutritional Counseling or only Tobacco Counseling or may elect to cover both.

Aetna Life Insurance Company
Explanation of Variability
Dental Care Coverage
Schedule of Benefits
GR-9N
S-21-025
01

This form will be used for both a fee for service dental plan and a Preferred Provider Organization dental plan. When this form is issued as part of a:

- Fee for Service/Comprehensive dental plan: The "Network" column will not print for this type of plan. The cost-sharing that will apply to these benefits is the cost-sharing that appears under the "Out-of-Network" column. The heading "Out-of-Network" will be omitted.
- PPO dental plan: Both columns will print for this type of plan.

The reference to “Payable at 50-100%” will be used when Type A services are paid at a coinsurance. When this option is selected by a policyholder, the reference to “Maximum Allowable Amount” and the dollar amounts will be omitted under Type A services.

This Dental Care Schedule will be included if a policyholder’s plan includes coinsurance up to a maximum allowable amount for each covered service or supply.

General Comments

The fields in the upper right “header” are variable and illustrative. Upon issue they will be completed to reflect the name of the policyholder, the group policy number and the coverage effective date. This item may be omitted, appear only on the first page of each Schedule of Benefits or appear only on the cover page.

The services listed in the Dental Care Schedule are variable. Dental services or supplies may be included or omitted in accordance with the policyholder’s plan of benefits and with Aetna’s standard plan offerings. Dental services and supplies may be deleted or modified, or new dental services and supplies may be added as a result of changes in standard dental practice, technology and terminology, and as a result of coding changes recommended or adopted by the American Dental Association. Please be assured that any member copay for a new service or supply will not exceed 30% of the covered expense, and the plan coinsurance for a new service or supply will not be less than 30% of the covered expense. In addition, this variability will not be used to add new services and supplies if benefit limitations are also included. Should any benefit limitations apply Aetna will file forms to support the change(s).

The term “network” may be changed to “preferred”, “participating” or a term of similar meaning. The term “out-of-network” may be changed to “non-preferred”, “non-participating” or a term of similar meaning.

The term "maximum allowable amount" may be changed to "scheduled limit".

The list of covered services may be revised to move services from one category to another, or to consolidate services into one list.

Any references to “year” may be changed to "calendar year", “plan year”, “policy year”, “365 consecutive day period”, or “12 consecutive month period”. Any references to "6 months" may be changed to "6 consecutive month period".

Aetna Life Insurance Company
Explanation of Variability
Dental Care Coverage
Schedule of Benefits
GR-9N
S-21-025
01

In response to policyholder needs, a dental plan may cover only Type A dental expenses, Type A and Type B dental expenses, Type A and Type B and Type C dental expenses, or only Type C dental expenses.

The references to Type A, B, and C expenses will be deleted if services are consolidated into one list. The reference to Type C expenses will be deleted if these services are combined with the Type B expense list.

All endodontic, periodontic and/or oral surgery services, shown under Type B Services may be moved to Type C Services.

The section on orthodontics may be omitted if the policyholder's plan of benefits does not include coverage for orthodontia expenses. When Comprehensive orthodontic treatment is covered, the treatment may be limited to adolescent only or adult dentition only.

Type A Expenses: Diagnostic and Preventive, Type B Expenses: Basic Restorative Care and Type C Expenses: Major Restorative Care

Throughout the forms, there are bracketed amounts such as visit limits, ages, number of treatments, applications, sites, quadrants, and guards, or amounts which are stated in ranges. These ranges reflect Aetna's standard offerings. However, in some instances, different amounts may print in a form issued to a policyholder but only if the amounts are more liberal to the policyholder or the covered person. Please be assured that these more liberal amounts will not result in a departure from the intent and purpose of the provision and will be in full compliance with any applicable state laws and regulations.

Any expenses limited to children only (fluoride and sealants), may be expanded to adults. If expenses are expanded to adults, the references to covered persons will be removed.

Nutritional Counseling and Tobacco Counseling
When included, the contract holder may elect to cover only Nutritional Counseling or only Tobacco Counseling or may elect to cover both.

Aetna Life Insurance Company
Explanation of Variability
Comprehensive [Managed] Dental Expense Insurance
Schedule of Benefits
GR-9N
S-22-010
06

This Dental Care Schedule will be included if a policyholder's plan includes an in-network fixed fee copay schedule.

General Comments
The fields in the upper right "header" are variable and illustrative. Upon issue they will be completed to reflect the name of the policyholder, the group policy number and the coverage effective date. This item may be omitted, appear only on the first page of each Schedule of Benefits or appear only on the cover page.

The services listed in the Dental Care Schedule are variable. Dental services or supplies may be included or omitted in accordance with the policyholder's plan of benefits and with Aetna's standard plan offerings. Dental services and supplies may be deleted or modified, or new dental services and supplies may be added as a result of changes in standard dental practice, technology and terminology, and as a result of coding changes recommended or adopted by the American Dental Association. Please be assured that any member copay for a new service or supply will not exceed 30% of the covered expense, and the plan coinsurance for a new service or supply will not be less than 30% of the covered expense. In addition, this variability will not be used to add new services and supplies if benefit limitations are also included. Should any benefit limitations apply Aetna will file forms to support the change(s).

The term "network" may be changed to "preferred", "participating" or a term of similar meaning.

The list of covered services may be revised to move services from one category to another, or to consolidate services into one list.

Any references to "year" may be changed to "calendar year", "plan year", "policy year", "365 consecutive day period", or "12 consecutive month periods".

The section on orthodontics may be omitted if the policyholder's plan of benefits does not include coverage for orthodontia expenses. When Comprehensive orthodontic treatment is covered, the treatment may be limited to adolescent only or adult dentition only.

Throughout the forms, there are bracketed amounts such as visit limits, ages, number of treatments, applications, sites, quadrants, and guards, or dollar amounts which are stated in ranges. These ranges reflect Aetna's standard offerings. However, in some instances, different amounts may print in a form issued to a policyholder but only if the amounts are more liberal to the policyholder or the covered person. Please be assured that these more liberal amounts will not result in a departure from the intent and purpose of the provision and will be in full compliance with any applicable state laws and regulations.

Any expenses limited to children only (fluoride and sealants), may be expanded to adults. If expenses are expanded to adults, the references to covered persons will be removed.

Nutritional Counseling and Tobacco Counseling
When included, the contract holder may elect to cover only Nutritional Counseling or only Tobacco Counseling or may elect to cover both.

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This Dental Care Schedule will be included if a policyholder's plan includes an out-of-network fixed fee amount payable schedule.

General Comments
The fields in the upper right "header" are variable and illustrative. Upon issue they will be completed to reflect the name of the policyholder, the group policy number and the coverage effective date. This item may be omitted, appear only on the first page of each Summary of Benefits or appear only on the cover page.

The services listed in the Dental Care Schedule are variable. Dental services or supplies may be included or omitted in accordance with the policyholder's plan of benefits and with Aetna's standard plan offerings. Dental services and supplies may be deleted or modified, or new dental services and supplies may be added as a result of changes in standard dental practice, technology and terminology, and as a result of coding changes recommended or adopted by the American Dental Association. Please be assured that any member copay for a new service or supply will not exceed 30% of the covered expense, and the plan coinsurance for a new service or supply will not be less than 30% of the covered expense. In addition, this variability will not be used to add new services and supplies if benefit limitations are also included. Should any benefit limitations apply Aetna will file forms to support the change(s).

The term "out-of-network" may be changed to "non-preferred", "non-participating" or a term of similar meaning.

The list of covered services may be revised to move services from one category to another, or to consolidate services into one list.

Any references to "year" may be changed to "calendar year", "plan year", "policy year", "365 consecutive day period", or "12 consecutive month periods".

The section on orthodontics may be omitted if the policyholder's plan of benefits does not include coverage for orthodontia expenses. When Comprehensive orthodontic treatment is covered, the treatment may be limited to adolescent only or adult dentition only.

Throughout the forms, there are bracketed amounts such as visit limits, ages, number of treatments, applications, sites, quadrants, and guards, or dollar amounts which are stated in ranges. These ranges reflect Aetna's standard offerings. However, in some instances, different amounts may print in a form issued to a policyholder but only if the amounts are more liberal to the policyholder or the covered person. Please be assured that these more liberal amounts will not result in a departure from the intent and purpose of the provision and will be in full compliance with any applicable state laws and regulations.

Any expenses limited to children only (fluoride and sealants), may be expanded to adults. If expenses are expanded to adults, the references to covered persons will be removed.

Nutritional Counseling and Tobacco Counseling
When included, the contract holder may elect to cover only Nutritional Counseling or only Tobacco Counseling or may elect to cover both.

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Comprehensive Dental Expense Insurance
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This section will be included for a policyholder's managed dental plan which calculates a benefit and a percentage copayment for network covered services using coinsurance and pays a scheduled benefit amount for each out-of-network covered service.

General Comments
The fields in the upper right "header" are variable and illustrative. Upon issue they will be completed to reflect the name of the policyholder, the group policy number and the coverage effective date. This item may be omitted, appear only on the first page of each S**chedule** of Benefits or appear only on the cover page.

The "Network" heading may be changed to "in-network", "participating", "preferred" or some other term of similar meaning. The "Out-of-Network" heading may be changed to "non-participating", non-preferred", "non-network' or another term of similar meaning.

Variability, as indicated by brackets surrounding variable text, is required so that only the appropriate information will be reflected based upon the plan of benefits or provisions selected by the customer.

Throughout the form are bracketed dollar and copayment amounts which are stated in ranges. These ranges reflect Aetna's standard offerings. However, in some instances, different amounts may print in a form issued to a policyholder but only if the amounts are more liberal to the policyholder or the covered person. Please be assured that these more liberal amounts will not result in a departure from the intent and purpose of the provision and will be in full compliance with any applicable state laws and regulations.

Dental Care Schedule Copayment Amounts
This Schedule shows the copayment percentage that a covered person pays.

The references to Type A, B, and C expenses will be deleted if services are consolidated into one list. The reference to Type C expenses will be deleted if these services are combined with the Type B expense list.

In response to policyholder needs, a dental plan may cover only Type A dental expenses, Type A and Type B dental expenses, Type A and Type B and Type C dental expenses, or only Type C dental expenses.

Orthodontic expenses may be expressed as a copayment percentage or a fixed amount not to exceed $5,000.

Orthodontics
The benefit payable for orthodontic expenses may also be expressed as a copayment amount.

Out-of-Network Dental Provider Covered Expenses
This will be included when the dental plan covers services provided by out-of-network providers.

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This Dental Care Schedule will be included if a policyholder's plan includes an out-of-network fixed fee amount payable schedule.

General Comments
The fields in the upper right "header" are variable and illustrative. Upon issue they will be completed to reflect the name of the policyholder, the group policy number and the coverage effective date. This item may be omitted, appear only on the first page of each Summary of Benefits or appear only on the cover page.

The services listed in the Dental Care Schedule are variable. Dental services or supplies may be included or omitted in accordance with the policyholder's plan of benefits and with Aetna's standard plan offerings. Dental services and supplies may be deleted or modified, or new dental services and supplies may be added as a result of changes in standard dental practice, technology and terminology, and as a result of coding changes recommended or adopted by the American Dental Association. Please be assured that any member copay for a new service or supply will not exceed 30% of the covered expense, and the plan coinsurance for a new service or supply will not be less than 30% of the covered expense. In addition, this variability will not be used to add new services and supplies if benefit limitations are also included. Should any benefit limitations apply Aetna will file forms to support the change(s).

The term "out-of-network" may be changed to "non-preferred", "non-participating" or a term of similar meaning.

The list of covered services may be revised to move services from one category to another, or to consolidate services into one list.

Any references to "year" may be changed to "calendar year", "plan year", "policy year", "365 consecutive day period", or "12 consecutive month periods".

The section on orthodontics may be omitted if the policyholder's plan of benefits does not include coverage for orthodontia expenses. When Comprehensive orthodontic treatment is covered, the treatment may be limited to adolescent only or adult dentition only.

Throughout the forms, there are bracketed amounts such as visit limits, ages, number of treatments, applications, sites, quadrants, and guards, or dollar amounts which are stated in ranges. These ranges reflect Aetna's standard offerings. However, in some instances, different amounts may print in a form issued to a policyholder but only if the amounts are more liberal to the policyholder or the covered person. Please be assured that these more liberal amounts will not result in a departure from the intent and purpose of the provision and will be in full compliance with any applicable state laws and regulations.

The references to Type A, B, and C expenses will be deleted if services are consolidated into one list. The reference to Type C expenses will be deleted if these services are combined with the Type B expense list.

In response to policyholder needs, a dental plan may cover only Type A dental expenses, Type A and Type B dental expenses, Type A and Type B and Type C dental expenses, or only Type C dental expenses.

Any expenses limited to children only (fluoride and sealants), may be expanded to adults. If expenses are expanded to adults, the references to covered persons will be removed.

Nutritional Counseling and Tobacco Counseling
When included, the contract holder may elect to cover only Nutritional Counseling or only Tobacco Counseling or may elect to cover both.

Aetna Life Insurance Company
Explanation of Variability
Schedule of Benefits
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S-30-010
07

General Comments

The fields in the upper right "header" are variable and illustrative. Upon issue they will be completed to reflect the name of the policyholder, the group policy number and the coverage effective date. This item may be omitted, appear only on the first page of each Schedule of Benefits or appear only on the cover page.

The services listed in the Dental Care Schedule are variable. Dental services or supplies may be included or omitted in accordance with the policyholder's plan of benefits and with Aetna's standard plan offerings. Dental services and supplies may be deleted or modified, or new dental services and supplies may be added as a result of changes in standard dental practice, technology and terminology, and as a result of coding changes recommended or adopted by the American Dental Association. Please be assured that any member copay for a new service or supply will not exceed 30% of the covered expense, and the plan coinsurance for a new service or supply will not be less than 30% of the covered expense. In addition, this variability will not be used to add new services and supplies if benefit limitations are also included. Should any benefit limitations apply Aetna will file forms to support the change(s).

The term "network" may be changed to "preferred", "participating" or a term of similar meaning.

The list of covered services may be revised to move services from one category to another, or to consolidate services into one list.

Any references to "year" may be changed to "calendar year", "plan year", "policy year", "365 consecutive day period", or "12 consecutive month periods".

The section on orthodontics may be omitted if the policyholder's plan of benefits does not include coverage for orthodontia expenses. When Comprehensive orthodontic treatment is covered, the treatment may be limited to adolescent only or adult dentition only.

Throughout the forms, there are bracketed amounts such as visit limits, ages, number of treatments, applications, sites, quadrants, and guards, or dollar amounts which are stated in ranges. These ranges reflect Aetna's standard offerings. However, in some instances, different amounts may print in a form issued to a policyholder but only if the amounts are more liberal to the policyholder or the covered person. Please be assured that these more liberal amounts will not result in a departure from the intent and purpose of the provision and will be in full compliance with any applicable state laws and regulations.

Any expenses limited to children only (fluoride and sealants), may be expanded to adults. If expenses are expanded to adults, the references to covered persons will be removed.

Nutritional Counseling and Tobacco Counseling

When included, the contract holder may elect to cover only Nutritional Counseling or only Tobacco Counseling or may elect to cover both.

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16-025
03

General Comments

The words “Alternate”, “Expense” and “Insurance” may be omitted.

The term “Plan” may be changed to “Coverage”.

The term “network” may be changed to “preferred”, “participating” or a term of similar meaning. The term “out-of-network” may be changed to “non-preferred”, “non-participating” or a term of similar meaning.

The term “maximum allowable amount” may be changed to “scheduled limit”.

The term “recognized charge” may be changed to “recognized amount”.

The term “coinsurance limit” may be changed to “payment limit”.

The term “Schedule of Benefits” may be changed to “Summary of Benefits”, “Schedule of Coverage” or “Summary of Coverage”.

The references to cost sharing will be included or omitted as applicable to the policyholder’s plan. The term “copays” may be changed to “copayment”.

The applicable page number at the bottom of the form will print upon issue.

The bracketed designations [00000] at the bottom right corner is a field reserved for Aetna's use to allow for the addition of a drafting system code that assists with the electronic assembly of Policyholder specific documents. Upon issue of this form, the bracketed term [State] will be omitted if the page has not been modified due to state requirements. If the page has been modified, then the postal abbreviation of your state may be added to identify that the form is state specific.

Using Network Providers

The second bullet will be included when the plan includes a deductible. When included, it may be changed to indicate the type of deductible or deductibles that apply, such as ”family”, ”network” or ”plan year”.

In the third bullet, the sentence that begins with,”[y]ou share the cost…” will be ommited or changed should the policyholder’s plan cover in-network services at 100%. The sentence that begins with, “[h]owever, if the negotiated charge…” will be included when the plan includes a maximum allowable amount.

The fourth bullet will be included when the plan includes a maximum allowable amount.

In the fifth bullet, the sentence that begins with “Aetna will directly pay…” will be omitted for plans where Aetna does not pay the provider.

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In the sixth bullet, the bracketed sentence will print when insureds have the option of selecting paper or electronic communication. As department names may change over time, the reference to Member Services in the last sentence may change.

Using Out-of-Network Providers

The third paragraph will be included when the plan includes a deductible. When included, it may be changed to indicate the type of deductible or deductibles that apply, such as ”family”, ”network” or ”plan year”.

The fifth paragraph will be included when the plan includes a maximum allowable amount.

In the sixth paragraph, the sentence that begins with “[t]hat excess amount…” will be included when a plan includes a coinsurance limit.

Important Reminder

The sentence that begins with “[t]here is a separate deductible…” will be included when a policyholder’s plan includes orthodontic treatment and any deductibles and/or benefit maximums apply.

Aetna Life Insurance Company
Explanation of Variability
GR-9N
18-006
02

This dental option is available to plan sponsors who purchase an Aetna dental plan.

General Comments

The services listed in the Dental Care Schedule are variable. Dental services or supplies may be included or omitted in accordance with the policyholder's plan of benefits and with Aetna's standard plan offerings. Dental services and supplies may be deleted or modified, or new dental services and supplies may be added as a result of changes in standard dental practice, technology and terminology, and as a result of coding changes recommended or adopted by the American Dental Association. Please be assured that any member copay for a new service or supply will not exceed 30% of the covered expense, and the plan coinsurance for a new service or supply will not be less than 30% of the covered expense. In addition, this variability will not be used to add new services and supplies if benefit limitations are also included. Should any benefit limitations apply Aetna will file forms to support the change(s).

The entire list may be moved to the Schedule of Benefits.

Any references to "year" may be changed to "calendar year", "plan year", "policy year", "365 consecutive day period", or "12 consecutive month period".

References to Type A, B or C Expenses may be included or omitted, or they may be changed to Diagnostic and Preventive, Basic Restorative Care, and Major Restorative Care respectively.

In response to policyholder needs, a dental plan may cover only Type A dental expenses, Type A and Type B dental expenses, Type A and Type B and Type C dental expenses, or only Type C dental expenses.

The references to Type A, B, and C expenses will be deleted if services are consolidated into one list. The reference to Type C expenses will be deleted if these services are combined with the Type B expense list.

Dental Expense Insurance Plan

1. Either "Limited", "Comprehensive" or "PPO" will appear in accordance with the policyholder's plan of benefits. The term "insurance" may be changed to "coverage" or "benefits". The term "plan" may be included.

2. Reference to dependents will be included when dependents are covered under the policyholder's plan.

3. The list of medical conditions which allows a covered person to be eligible may be limited to one or more of the four conditions.The list of medical conditions may also be expanded to add additional conditions as supported by clinical data and the American Dental Association.

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Explanation of Variability
GR-9N
18-006
02

Additional Covered Dental Expenses

4. The list of Covered Dental Expenses is variable and the policyholder can choose to include any one, any combination or all the expenses. Other covered expenses for diagnostic, preventive and basic dental services may be added to the covered expenses list at 100% coverage when the insured has one of the above conditions.

   The entire list of covered services may be moved to the Schedule of Benefits. Dental terminology may be changed to reflect new terminology adopted by the American Dental Association.

Payment of Benefits

5. If the plan is a traditional fee-for-service plan, or if the PPO plan does not contain a coinsurance differential between in and out-of-network benefits, references to network and out-of-network will be omitted.

6. The plan coinsurance may range from 50% -100% for a fee for service plan or out-of-network expenses for a PPO plan. References to network and out-of-network will not appear if the policyholder's plan is a traditional fee-for-service plan.

7. In the second paragraph, references to copayments and deductibles will be omitted if not applicable to a particular policyholder's plan.

8. References to calendar year maximum will be omitted if the plan does not include a calendar year maximum.

Aetna Life Insurance Company
Explanation of Variability
GR-9N
18-010
05

This form will be used when the policyholder elects a dental coinsurance plan.

General Comments

The services listed in the Dental Care Schedule are variable. Dental services or supplies may be included or omitted in accordance with the policyholder's plan of benefits and with Aetna's standard plan offerings. Dental services and supplies may be deleted or modified, or new dental services and supplies may be added as a result of changes in standard dental practice, technology and terminology, and as a result of coding changes recommended or adopted by the American Dental Association. Please be assured that any member copay for a new service or supply will not exceed 30% of the covered expense, and the plan coinsurance for a new service or supply will not be less than 30% of the covered expense. In addition, this variability will not be used to add new services and supplies if benefit limitations are also included. Should any benefit limitations apply Aetna will file forms to support the change(s).

The entire list may be moved to the Schedule of Benefits.

Any references to "year" may be changed to "calendar year", "plan year", "policy year", "365 consecutive day period", or "12 consecutive month periods". Any references to "6 months" may be changed to "6 consecutive month periods".

The list of covered services may be revised to move services from one category to another, or to consolidate services into one list.

References to Type A, B or C Expenses may be included or omitted, or they may be changed to Diagnostic and Preventive, Basic Restorative Care, and Major Restorative Care respectively.

In response to policyholder needs, a dental plan may cover only Type A dental expenses, Type A and Type B dental expenses, Type A and Type B and Type C dental expenses, or only Type C dental expenses.

The references to Type A, B, and C expenses will be deleted if services are consolidated into one list. The reference to Type C expenses will be deleted if these services are combined with the Type B expense list.

All endodontic, periodontic and/or oral surgery services, shown under Type B Services may be moved to Type C Services.

The section on orthodontics will be omitted if the policyholder's plan of benefits does not include coverage for orthodontia expenses. When Comprehensive orthodontic treatment is covered, the treatment may be limited to adolescent only or adult dentition only.

Important Reminder

References to copays and deductibles will be omitted if not applicable to a particular policyholder's plan.

The second and third paragraphs will be omitted if the policyholder's plan does not use a network.

If the item is included, the term "network" may be replaced with "in-network"; "preferred"; or "participating" and the term "out-of-network" may be replaced with "non-preferred" or "non-participating".

The term "Schedule of Benefits" may be changed to "Summary of Benefits", "Summary of Coverage", or "Schedule of Coverage".

Type A Expenses: Diagnostic and Preventative Care, Type B Expenses: Basic Restorative Care and Type C Expenses: Major Restorative Care

Throughout the forms, there are bracketed amounts such as visit limits, ages, number of treatments, applications, sites, quadrants, and guards, or amounts which are stated in ranges. These ranges reflect Aetna's standard offerings. However, in some instances, different amounts may print in a form issued to a policyholder but only if the amounts are more liberal to the policyholder or the covered person. Please be assured that these more liberal amounts will not result in a departure from the intent and purpose of the provision and will be in full compliance with any applicable state laws and regulations.

Any expenses limited to children only (fluoride and sealants), may be expanded to adults. If expenses are expanded to adults, the references to covered persons will be removed.

Nutritional Counseling and Tobacco Counseling

When included, the contract holder may elect to cover only Nutritional Counseling or only Tobacco Counseling or may elect to cover both.

Aetna Life Insurance Company
Explanation of Variability
GR-9N
19-006
02

This dental option is available to plan sponsors who purchase an Aetna dental plan.

General Comments

The services listed in the Dental Care Schedule are variable. Dental services or supplies may be included or omitted in accordance with the policyholder's plan of benefits and with Aetna's standard plan offerings. Dental services and supplies may be deleted or modified, or new dental services and supplies may be added as a result of changes in standard dental practice, technology and terminology, and as a result of coding changes recommended or adopted by the American Dental Association. Please be assured that any member copay for a new service or supply will not exceed 30% of the covered expense, and the plan coinsurance for a new service or supply will not be less than 30% of the covered expense. In addition, this variability will not be used to add new services and supplies if benefit limitations are also included. Should any benefit limitations apply Aetna will file forms to support the change(s).

The entire list may be moved to the Schedule of Benefits.

Any references to "year" may be changed to "calendar year", "plan year", "policy year", "365 consecutive day period", or "12 consecutive month period".

References to Type A, B or C Expenses may be included or omitted, or they may be changed to Diagnostic and Preventive, Basic Restorative Care, and Major Restorative Care respectively.

In response to policyholder needs, a dental plan may cover only Type A dental expenses, Type A and Type B dental expenses, Type A and Type B and Type C dental expenses, or only Type C dental expenses.

The references to Type A, B, and C expenses will be deleted if services are consolidated into one list. The reference to Type C expenses will be deleted if these services are combined with the Type B expense list.

Dental Expense Insurance Plan

1. Either "Comprehensive" or "Managed" will appear in accordance with the policyholder's plan of benefits. The term "insurance may be changed to "coverage" or "benefits". The term "plan" may be included.

2. Reference to dependents will be included when dependents are covered under the policyholder's plan.

3. The list of medical conditions which allows a covered person to be eligible may be limited to one or more of the four conditions. The list may also be expanded to add additional medical conditions As supported by clinical data and the American Dental Association.

Aetna Life Insurance Company
Explanation of Variability
GR-9N
19-006
02

Additional Covered Dental Expenses

4. The list of Covered Dental Expenses is variable and the policyholder can choose to include any one, any combination or all the expenses. Other covered expenses for diagnostic, preventive and basic dental services may be added to the covered expenses list at 100% coverage when the insured has one of the above conditions.

Payment of Benefits

5. The plan coinsurance may range from 50% -100%.

6. References to out-of-network expenses will be omitted if the plan selected does not include out-of-network expenses.

7. The second paragraph will be included if the plan includes copayments.

Aetna Life Insurance Company
Explanation of Variability
GR-9N
19-010
04

General Comments:

The services listed in the Dental Care Schedule are variable. Dental services or supplies may be included or omitted in accordance with the policyholder's plan of benefits and with Aetna's standard plan offerings. Dental services and supplies may be deleted or modified, or new dental services and supplies may be added as a result of changes in standard dental practice, technology and terminology, and as a result of coding changes recommended or adopted by the American Dental Association. Please be assured that any member copay for a new service or supply will not exceed 30% of the covered expense, and the plan coinsurance for a new service or supply will not be less than 30% of the covered expense. In addition, this variability will not be used to add new services and supplies if benefit limitations are also included. Should any benefit limitations apply Aetna will file forms to support the change(s).

The term "network" may be changed to "in-network", "preferred", "participating" or a term of similar meaning.

The entire list may be moved to the Schedule of Benefits.

Any references to "year" may be changed to "calendar year", "plan year", "policy year", "365 consecutive day period", or "12 consecutive month periods".

References to Type A, B or C Expenses may be included or omitted, or they may be changed to Diagnostic and Preventive, Basic Restorative Care, and Major Restorative Care respectively.

The references to Type A, B, and C expenses will be deleted if services are consolidated into one list. The reference to Type C expenses will be deleted if these services are combined with the Type B expense list.

All endodontic, periodontic and/or oral surgery services, shown under Specialty Dental Services Type B Expenses may be moved to Specialty Dental Services Type C Expenses.

The section on orthodontics will be omitted if the policyholder's plan of benefits does not include coverage for orthodontia expenses. When Comprehensive orthodontic treatment is covered, the treatment may be limited to adolescent only or adult dentition only.

Throughout the forms, there are bracketed amounts such as visit limits, ages, number of treatments, applications, sites, quadrants, and guards, or amounts which are stated in ranges. These ranges reflect Aetna's standard offerings. However, in some instances, different amounts may print in a form issued to a policyholder but only if the amounts are more liberal to the policyholder or the covered person. Please be assured that these more liberal amounts will not result in a departure from the intent and purpose of the provision and will be in full compliance with any applicable state laws and regulations.

Any expenses limited to children only (fluoride and sealants), may be expanded to adults. If expenses are expanded to adults, the references to covered persons will be removed.

Nutritional Counseling and Tobacco Counseling

When included, the contract holder may elect to cover only Nutritional Counseling or only Tobacco Counseling or may elect to cover both.

Aetna Life Insurance Company
Explanation of Variability
GR-9N
20-005
03

General Comments

Variability, as indicated by brackets surrounding variable text, is required so that only the appropriate information will be reflected.

This form contains bracketed time periods and ages which are stated in ranges. These ranges reflect Aetna's standard offerings. However, in some instances, different amounts may print in a form issued to a policyholder but only if the amounts are more liberal to the policyholder or the covered person. Please be assured that these more liberal amounts will not result in a departure from the intent and purpose of the provision and will be in full compliance with any applicable state laws and regulations.

Orthodontic Treatment Rule

1. Coverage for orthodontic treatment is an option for the policyholder.

2. The policyholder may choose to only provide coverage for dependent children. When that is the case the bracketed statement “on the date active orthodontic treatment begins” may be replaced with “on the date the appliance is initially inserted”.

   The policyholder may also choose to provide coverage to employees or subscribers only, adults only or all covered persons. When that is the case, the dependent language in the first paragraph may be replaced, for example, with “for you only”, “for you and your covered dependent spouse” or ”you and your covered dependents”.

3. In the second paragraph, the policyholder may elect to include any combination of, or all of the bulleted limitations.

4. The third paragraph may be omitted if not elected by the policyholder.

Orthodontic Limitation for Late Enrollees

5. The limitation for late enrollees will be omitted when:
   - Not applicable to the policyholder’s plan; or
   - The dental plan is integrated with a medical plan and, as a result, becomes subject to HIPAA.

Waiting Period

6. The inclusion of a waiting period or different waiting periods is an option for the policyholder.

7. The second sentence will be omitted if Type B expenses do not have a waiting period.

8. The third sentence will be omitted if Type C expenses do not have a waiting period.

9. The last sentence will be omitted if orthodontic treatment does not have a waiting period.

Aetna Life Insurance Company
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GR-9N
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02

General Comments

Variability, as indicated by brackets surrounding variable text, is required so that only the appropriate information will be reflected.

This form contains bracketed time periods which are stated in ranges. These ranges reflect Aetna's standard offerings. However, in some instances, different amounts may print in a form issued to a policyholder but only if the amounts are more liberal to the policyholder or the covered person. Please be assured that these more liberal amounts will not result in a departure from the intent and purpose of the provision and will be in full compliance with any applicable state laws and regulations.

Replacement Rule

1. This rule is an option for the policyholder.

2. In the first sentence of the first paragraph and in second bulleted item, the policyholder can select any combination of or all items in the list of services to be subject to the replacement rule.

3. The policyholder may elect to include any combination of or all of the bulleted items.

Tooth Missing But not Replaced Rule

4. This rule is an option for the Policyholder.

The second bulleted item is optional for the Policyholder. When included, the reference to extraction of a third molar may be omitted.

Aetna Life Insurance Company
Exclusions that Apply to [Basic][Limited][DMO][PPO][Comprehensive] Dental Insurance
Explanation of Variability
GR-9N
28-025
04

General Comments

Throughout this section, each bracketed exclusion may be omitted, or specific services or supplies mentioned within the exclusion may be omitted if the policyholder has elected to provide coverage, or the exclusion is already listed in the medical exclusions section.

The reference to *What the Plan Covers* may be changed to some other name of similar meaning as used in the policyholder's forms.

The references to "Booklet-Certificate" may be changed to "Certificate", "Certificate of Insurance" or some other name of similar meaning as used in a policyholder's forms.

The reference to "network" may be changed to "in-network"; "preferred"; or "participating" and the term "out-of-network" may be changed to "non-preferred" or "non-participating".

The exclusions in this section may be moved to the medical exclusions list when Aetna medical coverage is also purchased.

Exclusions That Apply to Dental Insurance

Heading: The product plan name applicable to the policyholder's coverage will print.

The second paragraph will print for plans when an Aetna medical plan is purchased with the dental coverage.

The exclusion for services or supplies furnished by a network provider to the extent that the negotiated charge exceeds any maximum allowable amount will be included for PPO plans that include a maximum allowable amount schedule.

The exclusion for services and supplies provided by an out-of-network provider will be included for DMO plans.

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General Comments

- Variability, as indicated by brackets surrounding variable text, is required so that only the appropriate information will be reflected based upon the plan of benefits or provisions selected by the Policyholder.
- The placement of the text within the form may vary to avoid gaps that would otherwise be created by the deletion of bracketed text or may be changed to allow the contractual documents to be system produced.
- The references to "Schedule of Benefits" may be changed to “Summary of Benefits”, “Schedule of Coverage” or “Summary of Coverage".
- The references to "Booklet-Certificate" may be changed to "Certificate", "Certificate of Insurance" or some other name of similar meaning as used in a policyholder's forms.
- The section references may be changed to reflect the correct section or additional section references may be included as appropriate for the policyholder’s plan.
- The references to “network” may be changed to “in-network”, “participating”, “preferred” or some other term of similar meaning.
- The references to “out-of-network’ may be changed to “non-participating”, non-preferred”, “non-network’ or some other term of similar meaning.
- A particular definition will appear in this Glossary for the Booklet-Certificate only when that term is applicable to the plan of benefits purchased by the policyholder. Therefore, any definition may be included.
- Any definition on this form that is used within a specific section of the Booklet-Certificate may be moved to, or duplicated, in that section to assist readers to better understand the applicable covered expenses or provisions.
- If a term is approved with multiple options, for example (e.g. “formulary” changed to “preferred drug list”), then that defined term will be integrated under the appropriate alphabetical listing within this glossary. For the example given, it would mean that the drug guide definition would move from “F” to “P” within the issued documents
- The applicable page number at the bottom of the form will print upon issue.
- The bracketed designations [00000] at the bottom right corner is a field reserved for Aetna's use to allow for the addition of a drafting system code that assists with the electronic assembly of Policyholder specific documents. Upon issue of this form, the bracketed term [State] will be omitted if the page has not been modified due to state requirements. If the page has been modified, then the postal abbreviation of your state may be added to identify that the form is state specific.

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- *Coinsurance*: The second paragraph will print when the plan includes a maximum allowable amount provision. The first sentence will print for plans that include a network component and the maximum allowable amount applies to network providers. The second sentence will print for Major and Comprehensive Medical plans. It will also print for plans that include a network component and the maximum allowable amounts apply to out-of-network providers and/or for other health care.
- *Coinsurance Limit:* The term “Coinsurance Limit” may be changed to "Payment Limit". In addition, the term may be changed to “Maximum Out-of-Pocket Limit” for those plans where any applicable copayments and deductibles accumulate toward the limits. Any references to “calendar year” may be changed to “policy year”, “coverage year”, “plan year” or other interval. The sentences that apply to network and out-of-network benefits will print for plans with a network component that have either separate or combined limits for such benefits.
- *Coma or Comatose:* The “or your covered dependent” will print when dependents are covered under the plan.
- *Consumer Price Index*: The bracketed phrase "unadjusted U.S. City Average" will print when applicable to a policyholder's plan.